DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G699		LDING	ONSTRUCTION 00	(X3) DATE COMPL 01/25/	ETED
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE AYES ST		
ARC OF	NORTHWEST IND	DIANA INC, THE			LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W0000	(Client Protection Services). Dates of Survey and 1/25/13 Facility Number Provider Number AIMS Number: Surveyors: Paula Chika, Me Leader Christine Colon These federal de state findings in 9. Quality Review	nd state licensure survey ons and Health Care T: 1/14, 1/15, 1/16, 1/17 T: 003132 er: 15G699	WO	000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		15G699	B. WIN			01/25/	2013
NAME OF B	DOLUBED OF GUIDNIES			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			6101 H	AYES ST		
	NORTHWEST INDI	ANA INC, THE		MERRII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0104	483.410(a)(1) GOVERNING BO	DDY dy must exercise general					
		nd operating direction over					
	•	ation, interview and	W0	104	The couches in the living room	ı	02/24/2013
		r 2 of 2 sampled clients			will be cleaned within the allotted		_
		for 2 additional clients			time frame. To ensure future		
	, ,	governing body failed to			compliance, Area Manager will have couches cleaned as		
	exercise general	policy, budget and			needed.Policies and procedure	es	
	operating direction	on over the facility to			are in place which addresses		
	ensure the clients	s' living room couches			visitors being in a group home		
		d/or replaced due to urine			where clients live and where still lives. To ensure future		
		ning body failed to			compliance, Area Manager has	s	
	_	policy and operating			addressed this policy with		
		e facility to develop			staff.Client #2 ISP will be		
		and/or procedures/rules			modified to address his urinatii	•	
	•	ving in a group home			on himself and other objects. T		
		ided, and/or a policy and			ensure future compliance, clier issues will be addressed at	IL	
					annual meetings.The Nursing		
	-	addressed visitors being			manager has implement woun	d	
		where the clients lived			tracking records and reposition	ning	
	*	n resided to ensure the			charts at the group home.		
	protection of the	clients.			Repositioning charts were also sent to the day service prograr		
					To ensure future compliance,	•••	
		ation, interview and			records will be monitored at lea	ast	
		r 2 of 2 sampled clients			monthly. See W - 149Service		
		for 2 additional clients			Coordinator will train group ho	me	
	(#3 and #4), the	governing body failed to			staff on closing doors while clients are building and/or		
	exercise general	policy and operating			changing clothes.To ensure		
	direction over the	e facility to ensure the			future compliance, Service		
	facility did not no	eglect clients and/or			Coordinator will monitor twice		
	implement its po	licy and procedures to			monthly for 3 months then		
	conduct thorough investigations. The			monthly thereafter. See W154,			
	_	failed to exercise general			W331, W322, W336, W342, W369		
		ting direction over the					
	r J sma opera						

FORM CMS-2567(02-99) Previous Versions Obsolete

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G699	A. BUII	LDING	00	COMPL: 01/25/2	
		130099	B. WIN		DDDEGG GUTY GTATE TID GODE	01/23/	2013
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	its health care services					
		nd nursing needs of					
	clients.						
	Findings include						
	Tillulings illetude	•					
	1. During the 1/	15/13 observation period					
	_	M and 8:10 AM, at the					
	group home, the	re were 2 cars in the					
	driveway which	were frosted over upon					
	arrival to the hor	ne at 5:30 AM. One staff					
	, ,	en working at the group					
		was assisting client #2.					
		as observed in the group					
		AM, the surveyor walked					
		e house. The surveyor					
		standing in dining room					
	_	which exposed the staff's					
		identified male coming ted off the dining room.					
		male walked quickly to					
		d exited out the door.					
		taff #1 on 1/15/13 at 5:49					
		ought someone was here."					
		to the room/door off the					
		closed the door. During					
		oned observation period,					
		3 and #4 were in the					
		neir bedrooms. At 6:20					
		ne out of a door located					
	off the dining ro	om dressed for the day					
	and started work	ing.					
	Interview with P	rogram Coordinator (PC)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G699	B. WIN	G		01/25/	2013
NAME OF F	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					AYES ST		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		1:50 PM indicated					
		3 and #4 lived at the					
	• •	C #1 indicated at night,					
		f in the group home, one					
		sleep. When asked who					
		group home at night, PC					
		clients and staff. When					
		isitors should be in the					
		#1 indicated she did not					
		asked if the facility had a					
	1	to visitors, PC #1					
	_	estion would need to be					
	directed to admir	nistrative staff #3.					
	Intomvious svith D	C #1 and administrative					
		12 at 3:10 PM indicated					
	1 -	and the awake and asleep					
		t the group home at night.					
		staff #3 indicated staff #1					
		c from 10 PM to 6 AM.					
		taff #3 further indicated					
		the group home where					
	clients #1, #2, #3						
		taff #3 stated "It's her					
		of residence." When					
		paid rent, administrative					
		No. It's part of the perks."					
		en staff #1 could have					
	•	trative staff #3 and PC #1					
		he clients were not at the					
	group home duri	•					
		taff #3 again indicated it					
	_	ace of residence. When					
	asked if the facil	ity had a policy and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		15G699	B. WIN	G		01/25/20	013
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	FROVIDER OR SUFFLIER			6101 H	AYES ST		
	NORTHWEST IND	·		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	^	addressed a staff living					
		ne and/or when visitors					
		a group where a staff and					
		administrative staff #3					
		ought there was a policy.					
		staff #3 did not provide a					
		nd procedure in regard to					
		a group home and/or					
		in a group home where					
	clients and/or sta	aff resided.					
	Interview with s	taff #1 on 1/15/13 at 3:46					
	PM stated the ur	nidentified male, seen on					
	1/15/13 at the gr	oup home, was a					
	neighbor who ca	ame to the side door "to					
	get keys."						
	2. During the 1/	15/13 observation period					
	between 5:30 Al	M and 8:10 AM, at the					
	group home, 2 c	ouches were located in					
	the living room.	When near both					
	couches, the cou	iches had a strong					
	odor/smell. Inte	erview with staff #2 on					
	1/15/13 at 8:22	AM stated the smell on					
	the couches was	"urine." Staff #2 stated					
		s on couch and urinates."					
	1	v often the couches were					
		stated "We wipe off and					
	air out."						
	Client #2 record	was reviewed on 1/15/13					
	at 11:30 AM. C						
		ort Plan did not indicate					
		d on himself and/or					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE COMPL		
THIE TEAT	or condition	15G699		LDING		01/25/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1 0 20.	
NAME OF F	PROVIDER OR SUPPLIER				AYES ST		
ARC OF	NORTHWEST IND	IANA INC, THE			LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEF CHEVCT)		DATE
	objects.						
	Intorvious with D	C #1 on 1/15/13 at 1:50					
		e was not aware the					
		roup home had a urine					
	_	#2 urinating on the					
	couches.	72 difficulty on the					
	Couciios.						
	3. The governin	g body failed to exercise					
	_	nd operating direction					
		to ensure the facility					
	<u>-</u>	policy and procedures to					
	-	of client #1 in regard to					
		Foley Catheter. The					
		failed to exercise general					
		ting direction over the					
		the facility implemented					
	its written policy	and procedures to					
	prevent neglect of	of a wound on client #1's					
	foot/ankle. The	governing body failed to					
	exercise general	policy and operating					
	direction over th	e facility to ensure the					
	facility impleme	nted its written policy					
	and procedures i	n regard to conducting					
	investigations an	nd/or thorough					
	investigations of	possible neglect for					
	clients #2 and #3	3. Please see W149.					
	_	g body failed to exercise					
		nd operating direction					
	_	to protect client #2 and					
		en in the bathroom and/or					
	bathing. Please	see W130.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL		
		15G699	A. BUI B. WIN	LDING		01/25/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				AYES ST		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	_	g body failed to exercise					
		nd operating direction to provide evidence					
	1	horough investigations					
		d #3. Please see W154.					
	101 Chemis #2 and	u #3. Flease see W 134.					
	6. The governin	g body failed to exercise					
		nd operating direction					
	over the facility	to ensure its health care					
	services met the	health care/nursing needs					
	of clients in rega	rd to assessing,					
	monitoring a clie	ent for possible head					
	injury and to ens	sure a client obtained a					
	physical examin	ation. The governing					
	body failed to ex	tercise general policy and					
	operating directi	on over the facility to					
	ensure its health	care services ensured					
	staff called a nur	se when a client's health					
	_	ipdated a client's risk plan					
		eter, and to ensure staff					
		trained in regard to the					
		he Foley Catheter. The					
	1	failed to exercise general					
	1	ting direction over the					
	1	nursing services					
	· · · · · · · · · · · · · · · · · · ·	ored and/or addressed a					
		nt's ankle/foot, obtained					
		octor appointments and/or					
		injuries as needed for					
	clients #1, #2 an	d #3. Please see W331.					
	7 The governin	g body failed to exercise					
	_	nd operating direction					
		to ensure its health care					
		 					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		OATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		OMPLETED
		15G699	B. WING			1/25/2013
NAME OF P	ROVIDER OR SUPPLIER	3		ET ADDRESS, CITY, STA	TE, ZIP CODE	
				1 HAYES ST		
ARC OF	NORTHWEST IND	IANA INC, THE	MEF	RRILLVILLE, IN 4641	10	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PL	AN OF CORRECTION	(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCEI	E ACTION SHOULD BE D TO THE APPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFIC	CIENCY)	DATE
	services followe					
	_	y the physicians for client				
	#3. Please see V	V322.				
		g body failed to exercise				
	general policy ar	nd operating direction				
	over the facility	to ensure the facility's				
	health care servi	ces conducted quarterly				
	nursing assessme	ents in a timely fashion				
	for clients #1 and	d #2. Please see W336.				
	9. The governin	g body failed to exercise				
	general policy ar	nd operating direction				
		to ensure the facility's				
		ces adequately trained				
		client #1's Foley				
	Catheter. Please	-				
	Cumeter. Trease	7 500 11 5 12.				
	10 The governi	ng body failed to exercise				
	_	nd operating direction				
		to ensure the facility				
	-	ent #2's medication				
	without error. P					
	williout CITOI. P	icase see wyuy.				
	9-3-1(a)					
	y-3-1(a)					

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Event ID: 41PC11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G699	B. WIN	G		01/25/	2013
NAME OF E	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			6101 H	AYES ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		MERRII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0122	483.420 CLIENT PROTECT The facility must of protections required assed on observer record review, the Condition of Protections for 2 and #2) and for 1 The facility failed and procedures to clients in regard Catheter, a wound and in regard to a and/or conducting investigation in reallegations of new Findings include 1. The facility failed and procedures in regard to a client #1 in regard to a	ensure that specific client rements are met. ation, interview and refacility failed to meet Participation: Client of 2 sampled clients (#1 additional client (#3). d to implement policy o prevent neglect of to the care of a Foley and on a client's ankle/foot assessing a client's injury ag a thorough regard to possible glect/abuse. :: ailed to implement its dures to prevent neglect gard to the use/care of a The facility neglected to ritten policy and event neglect of a wound ot/ankle. The facility ent its written policy and gard to conducting	Wo	122	The Nurse manager has writte guidelines put in place for the of Foley Drainage equipment. Client is no longer using a Fole catheter. Wound tracking and repositioning records are in place. To ensure future compliance, staff will be traine as needed. Investigations will conducted if any neglect is suspected.	n use ey	DATE 02/24/2013
	2. The facility fa	ailed to protect client #2					
		when in the bathroom					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G699		A. BUILDING B. WING			COMPLETED 01/25/2013			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6101 HAYES ST MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		
	and/or bathing. 3. The facility fand/or conduct to	Please see W130. ailed to provide evidence horough investigations d #3. Please see W154.						

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Event ID: 41PC11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G699			LDING	ONSTRUCTION 00	(X3) DATE : COMPL 01/25/	ETED	
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE AYES ST LLVILLE, IN 46410	l	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
W0130	The facility must of clients. Therefore privacy during tre personal needs. Based on observe of 2 sampled client additional client to protect the clie bathroom and/or. Findings include During the 1/15/between 5:30 AM group home, clie bathroom sink. Stand/or encourage door, and/or close client's privacy, showered client abefore closing the fourths of the was facility staff showered showered.	13 observation period M and 8:10 AM, at the ent #2 stood in the playing in water at the Staff #2, who walked past imes did not prompt e client #2 to close the the the door to protect the At 6:35 AM, staff #2 #3 with the door open e bathroom door three	W0	130	Service Coordinator will train group home staff on closing doors while clients are bathing and/or changing clothes. To ensure future compliance, Service Coordinator will monit twice monthly for 3 months, the monthly thereafter.	tor	02/24/2013

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G699	A. BUILDING	00	COMPLETED 01/25/2013
		19098	B. WING		01/20/2013
NAME OF P	PROVIDER OR SUPPLIER	1		ADDRESS, CITY, STATE, ZIP CODE	
ARC OF	NORTHWEST IND	IANA INC, THE		AYES ST LLVILLE, IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G699		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/25/2013		
	PROVIDER OR SUPPLIER		5 . W.	STREET A	ADDRESS, CITY, STATE, ZIP CODE AYES ST LLVILLE, IN 46410	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
W0149	The facility must of written policies are mistreatment, neg Based on observative record review for (#1 and #2) and #2 (#3), the facility its written policy prevent neglect of the use/care of a facility neglected policy and proce of a wound on elfacility neglected policy and proce conducting investigations of clients #2 and #3 Findings include 1. The facility's reports and/or investigations of clients #2 and #3 indicated "Consulas as a walk-in pation office after being doctor). Consum to the hospital. Cannot and treatment of		W0	149	The Nursing manager has wriguidelines and a risk plan for Foley catheters. To ensure fut compliance, training records to be reviewed as needed to masure all staff are trained.	ure vill	02/24/2013

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Event ID: 41PC11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETE	
		15G699	B. WIN	G		01/25/20 ⁻	13
NAME OF P	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
450.05	NORTH WATERT IND				AYES ST		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE CO	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	_ _	catheter was put into					
	-	pressure of consumer's					
	bladder. He remains in the hospital (sic) duration is unknown at this time."						
	Client #1's record was reviewed on						
		AM. Client #1's 1/8/13					
	hospital Confide						
		losed record indicated					
	client #1 was admitted to the hospital as						
	the client could not urinate on 1/7/13. The						
		elient #1 was discharged					
		p home with a Foley					
	Catheter.						
	The 1/7/13 Urol	ogy Consult Note					
		on for Consult chronic					
		in this patient with a					
	_	e/vein) dementia, Down					
	syndrome and se						
	l -	sment 1. the patient was					
		eute chronic urinary					
	retention that the	•					
		nal (sic). He has a history					
		vn's syndrome and					
		outlet obstruction. Plan					
	. ^	nsider cystoscopy and					
	` ′						
	possible greenlight laser photo selective vaporization of the prostate. Additional						
	recommendation	-					
	1000mmendation	is to fullow.					
	Client #1's 1/7/13 Bladder Volume Echo						
		d thickening of the					
		h sludge within the					

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	OF CORRECTION OF CORRECTION 15G699	(X2) MULTIPLE CO A. BUILDING B. WING	00	СОМР	E SURVEY LETED 5/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	6101 H	ADDRESS, CITY, STATE, ZIP COI AYES ST LLVILLE, IN 46410	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	urinary bladder. The patient did not void for this exam."				
	Client #1's 1/9/13 Discharge Summary indicated client #1 was discharged on 1/9/13 and returned to the group home. The discharge summary indicated client #1 was to return to the doctor for his urinary retention. The discharge summary also indicated "Discharge Instructions "D/C (discontinue) foley in 1 week, if unable to urinate insert 16f foley and call [name of doctor] on [phone number]" Client #1's Cumulative Medical Record notes indicated the following (not all inclusive): -1/7/13 Client #1 saw his doctor in regard to no urinary output. The note indicated client #1 was experiencing "Suprapubic				
	fullness with discomfort." The medical note indicated client #1's doctor diagnosed the client with "Urinary Retention" and ordered a STAT (immediate) bladder scan.				
	-1/14/13 "Late Entry I went to the group home to check on consumer VS (vital signs) stable. Assessment done his penis was swollen and painful to the touch. He has a foley catheter in place for Urinary Retention. I (LPN #1) advised staff to				

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Event ID: 41PC11

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If continuation sheet

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	OF CORRECTION OF CORRECTION 15G699	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMPI 01/25	ETED
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	6101 H	ADDRESS, CITY, STATE, ZIP CODE AYES ST LLVILLE, IN 46410	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	take him to the [name of hospital] emergency. He was taken to the ER (emergency room) and new orders received for his Dx (diagnosis) of Encounter for Foley Catheter replacement and UTI (Urinary Tract Infection) and medication and new medications orders received (sic). He will be seen by his urology doctor next week, Labs will be done on 1/15/13. Will continue to monitor consumer." Client #1's above mentioned medical record, which included the nurse notes, indicated the facility neglected to assess the client when he was discharged from the hospital on 1/9/13, to ensure facility staff monitored the client and/or called the facility nurse when client #1's health status changed. Client #1's 1/8/13 Health and Safety Memo (risk plan) from LPN #1 was provided and reviewed on 1/15/13 at 3:45 PM. The memo indicated the following: "Instructions for catheter care: -Keep the bag below the waist at all times -Bag needs to be hung on the frame of the bed at bedtime. It CANNOT be placed on the floor -Make sure the rubber tubing is 'free of kinks at all times'-Empty the bag into the white basin before bag is full -Measure the amount of urine using the				

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Event ID: 41PC11

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If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G699	A. BUII	LDING	NSTRUCTION 00	CON	TE SURVEY MPLETED 25/2013
		100099	B. WIN				23/2013
NAME OF I	PROVIDER OR SUPPLIEF	t		1	DDRESS, CITY, STATE, ZIP CO	DE	
4DC OF	NODTI IMECT IND	IANIA INIC. THE			YES ST		
	NORTHWEST IND			MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP		COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		sin and record it on the I					
	` ′ `	te & output) sheet daily					
	-Make sure you wash your hands before and after emptying the catheter and wear						
	gloves while har	ndling the urine bag					
	-If there is no urine output in 4 hours call your nurse immediately						
	Instructions for leg bag: -Disconnect the plastic tubing from the catheter bag						
	-Connect the tubing to the leg bag						
		g on the inside of the leg					
	_	bove and below the knee					
	_	s for a comfortable fit					
		straps are not too tight and					
	cutting off circul	-					
	_	o be worn only during the					
	day	o be worn only during the					
	1 -	pag every 2 hours as					
	sheet	rd the output on the I & O					
	2	ing output in A 1					
		ine output in 4 hours call					
	_	ediatelyS/S (Signs and					
	Symptoms) for a	a client with a Foley:					
	1 7	1 101					
	1. Temperature						
		usea and vomiting					
		derness, or signs of					
		swelling, redness, odor or					
	, -	scharge around site					
	4. Severe uncor	ntrolled pain					
	5. Difficulty bre	eathing, headache or					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED	
		15G699	B. WIN			01/25/2013	
		<u> </u>	p. ,, 11.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			AYES ST		
	NORTHWEST IND	IANA INC, THE			LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X:	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DAT	E
	visual disturband	ce					
	6. Hives						
		adaches or visual					
	disturbance						
	8. Extreme fatigue						
	9. Difficulty with or inability to urinate						
	10. Any other co	oncerns call nurse."					
	Client #1's hospi	ital records were reviewed					
	on 1/15/13 at 2:45 PM. The 1/12/13						
	Emergency Department note indicated						
	client #1's diagn	oses included, but were					
	1	Encounter for Foley					
	-	ment" and UTI, site not					
	_	/12/13 note indicated					
		arted on Levaquin					
		milligrams 1 tablet daily					
	, ,	wder apply three times a					
	1	11.5					
	_	The ER note indicated a					
		welling Bladder Catheter					
		laced in the client's					
		12/13 ER note had					
		structions attached to the					
		ctions indicated "You can					
	reduce the risk o	of infection if you:					
	I imit the man-	or of garma (hostaria)					
	-Limit the number of germs (bacteria)						
	entering your bla	auder.					
	-Protect the tissu	ne from injury.					
	-Keep the urinar	y pathways					
	openFOLLOW	V THESE PROCEDURES					
	TO LIMIT THE						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G699	A. BUILDING	00	COI	ATE SURVEY MPLETED /25/2013
NAME OF	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP		
ARC OF	NORTHWEST IND	IANA INC, THE		HAYES ST RILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) TERING THE	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	BLADDER					
	-	ds for 2 minutes with ore and after handling the				
	of the catheter to bowel movemen and catheter with	eal area and entire length vice daily and after each t. Wash urethral opening in soap and warm water, wash the rectal area.				
	reverse, cleanse where it connect	the leg bag to bed bag or the end of the catheter is to the tubing. Do this corously with an alcohol				
	daily after use.	nd night drainage bags Replace your drainage when you can no longer them.				
	below the level of allow urine to dr Lifting the bag of of your bladder (contaminated) u your bladder. If lift the bag higher	bing and collection bag of your bladder. This will rain properly by gravity. or tubing above the level will cause unclean urine to flow back into you must momentarily er than your bladder, such side to side, pinch the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR	EVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETE	
		15G699	B. WIN			01/25/201	13
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					AYES ST		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRII	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	G DEFICIENCY)		DATE
	catheter or tubin	g to prevent back-flow.					
		-8 glasses of water daily.					
		acteria out of the					
	bladder" The Catheter care instructions						
		tions to protect tissues					
		njured and how to keep					
		way open. The facility					
	_	nediately update the					
	1/8/13 risk plan to incorporate all of the 1/12/13 recommendations to prevent client #1 from potential infections.						
	1	ervice/training records					
	were reviewed o	n 1/15/13 at 1:12 PM.					
	The facility's Sta	iff Development					
	Individual Train	ing/Group Training					
	_	d LPN #1 trained staff #4					
		to client #1's Foley					
	Catheter and car	e on 1/9/13. The					
	inservice records	s indicated LPN #1					
	trained day servi	ce staff #6, #7, #8 and #9					
	on 1/10/13. The	facility's inservice					
	records indicated	d LPN #1 trained staff #3					
	and #10 on 1/11/	/13. The facility's					
	inservice records	s indicated staff #5					
	trained staff #1 o	on 1/14/13 but LPN #1					
	signed as the train	iner. The facility's 1/9,					
	1/10, 1/11 and 1/	/14/13 inservice training					
	records indicated	the facility neglected to					
	train staff #11 and #12 in regard to client						
	#1's Foley Catheter and care. The facility						
	neglected to ensi	ure facility staff was					
	adequately traine	ed in regard to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G699	B. WIN	G		01/25/	2013
NAME OF I	PROVIDER OR SUPPLIEF	· {			ADDRESS, CITY, STATE, ZIP CODE		
					AYES ST		
	NORTHWEST IND	IANA INC, THE		MERRII	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1710		ient #1's risk plan/health		1710			DITTE
	-	staff informed the nurse					
	of changes with the Foley catheter/client's						
	health.	the roley eatherer/ellelles					
	During the 1/15/	13 observation period					
	between 5:30 AM and 8:10 AM, at the						
		ff #2 worked as the night					
	awake staff at th	_					
		•					
	Interview with staff #1 on 1/15/13 at 6:45 AM indicated client #1 had a Foley						
	Catheter. Staff #	#1 stated she was trained					
	in regard to the	client's catheter care					
	"yesterday" (1/1	4/13). Staff #1 indicated					
	she had been on	vacation. When asked if					
	there was a writt	ten protocol, staff #1					
		d not know. Staff #1 was					
	not able to locate						
	_	risk plan in the home on					
	1/15/13.						
	Total to 14 F	(DC)					
		Program Coordinator (PC)					
		on 1/15/13 at 1:50 PM					
		#1 had been hospitalized tion. LPN #1 indicated					
	1	scharged from the hospital					
	on 1/9/13 or 1/10/13. LPN #1 indicated client #1 saw his doctor on 1/7/13 and						
	was admitted to the hospital on 1/7/13.						
	LPN #1 indicated she assessed the client on 1/12/13 (Saturday) when she had the						
		ER. LPN #1 stated she					
		roup home to check on					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G699	ĺ	LDING	NSTRUCTION 00	COM	e survey Pleted 5/2013
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP COE AYES ST LVILLE, IN 46410	DE	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX TAG	REGULATORY OR	ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	COMPLETION DATE
		he noticed client #1's len, red with pus coming					
	*	PN #1 stated "They					
	· · ·	d not call me. They					
	should have called." LPN #1 and PC #1						
	indicated facility staff were trained in regard to the care of the Foley Catheter						
	1 -	the nurse. PC #1 and					
		d they were not aware					
	staff #11 and #12 had not been trained in regard to client #1's Foley Catheter. When asked if client #1 had a						
		n for the Foley Catheter,					
		I have not seen one. In					
	-	ng or re-writing." LPN #1					
		rector of Nursing (DON) a policy and procedure					
		theter and the DON was					
	1	plan for the catheter.					
l		he DON on 1/15/13 at					
		ed a memo/protocol had I sent out to the group					
		N did not know why LPN					
		e of the memo/protocol.					
		ated she was in the					
	process of updat	ing the protocol/memo					
	and developing	a policy and procedure for					
ı	Foley Catheter c	are.					
ı		taff #1 on 1/15/13 at 3:46					
l		e memo for client #1's					
	_	vas found/located in the					
	Communication	book at the group home					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G699	A. BUIL	DING	NSTRUCTION 00	CC	DATE SURVEY DMPLETED 1/25/2013
		100000	B. WING				1720/2010
NAME OF F	PROVIDER OR SUPPLIEF	3			DDRESS, CITY, STATE, ZIP COL	DE	
ADC OF	NORTHWEST IND	IANIA INC. THE			AYES ST LVILLE, IN 46410		
					LVILLE, IN 404 10		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	CTION	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	COMPLETION DATE
IAG	on 1/15/13 at 3:4	·		IAG			DATE
	OII 1/13/13 at 3.2	HO FIVI.					
	T	1					
		dministrative staff #3 on					
		PM, by phone, indicated					
	staff #3 and #10 worked on 1/12/13						
		client #1 at the group					
		trative staff #3 indicated					
		#10 worked on 1/11/13					
		roup home. The above					
	mentioned inservice/training records indicated staff #3, #5 and #10 had been						
		to client #1's Foley					
	•	ol/risk plan, but neglected					
	to call the nurse	in regard to client #1's					
	health status cha	inge.					
	2. The facility's	reportable incident					
	reports and/or in	vestigations were					
	reviewed on 1/1	4/13 at 12:03 PM. The					
	facility's reporta	ble incident reports					
	indicated the fol	_					
	-11/2/12 "I (L.PN	N #1) received a phone					
	,	mer (client #1) having a					
		ner left ankle that had					
		an open sore. I asked if					
		l intact (sic) staff replied					
		taff to apply triple					
	-	ent to the area and cover					
	with a gauze. If the blister breaks, a loose flap of skin will hang over the wound.						
	_	_					
		is dirty or has pus					
		erneath, leave it alone					
	since it will keep the wound protected.						

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STATEMENT OF DEFIC AND PLAN OF CORREC		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G699		LDING	00	COM	ie survey ipleted 25/2013
NAME OF PROVIDER OF			•	STREET A	ADDRESS, CITY, STATE, ZIP AYES ST LLVILLE, IN 46410	CODE	
PREFIX (EAC	H DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
away the to see to that the staff to I will good possible doctor the hose Syndro Cellulity Osteom. The fact indicate stable of limits. having foot. Of for Sephospita from [r. hospita and Prohospita at this to Client and The control of the september of the sept	dead skins consured dead skins consured dead skins apply the et him into the consumer today and its expelitis (but ility's 11/2 deal " Consumer dealy dress and is 1." 2 "[Clier ame of he le consumer of he le consumer dealy dress and is 1." 2 "[Clier ame of he le consumer dealy dress and is 1." 4 "I's record at 11:31	it is safe to gently cut in. I went to the house mer and staff showed me in had come off. I advised is same treatment and that to the doctor as soon as mer seen by [name of d consumer was sent to direct admit for Sepsis tion bloodstream), Right infection) with one infection)." (13/12 follow-up report sumer (client #1) is in vital signs within normal ray and Bone Scan. He is ssing changes to his right will need long term care currently in the (1 #1] has been transferred to spital] to [name of ther treatment of Sepsis He remains in the ration of stay is unknown d was reviewed on AM. Client #1's lical Record (nurse and					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	l í	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		PLETED
		15G699	B. WING		. 01/2	25/2013
NAME OF F	PROVIDER OR SUPPLIEF	3	STRE	ET ADDRESS, CITY, STATE, ZIP	CODE	
				HAYES ST		
ARC OF	NORTHWEST IND	IANA INC, THE	MER	RRILLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	doctor notes) no	tes indicated the				
	following (not a	ll inclusive):				
	-11/2/12 Client #	#1 was seen by his doctor				
	for right ankle b	listers. The 11/2/12				
	doctor's note ind	licated client #1 was				
	"weak, sleeping	Ft (foot) necrotic (dead				
	tissue) (R) (right	t) great toe and lateral				
	foot wound with	foot cellulitis A				
	(Assessment):					
	(1) (R) Foot Ce	llulitis				
		eomyelitis with necrotic				
	wounds					
	(3) Possible Ser	osis SyndromeAdmit				
	with SS (Sepsis	•				
	, in so (sepsis	~ y 11 0 1 0111 0).				
	-11/2/12 "Consu	mer was seen by [name				
		for blister on his right				
	foot. He	3 3 3 3 3				
		[name of hospital] for				
		e (RT) cellulitis (with)				
	Osteomyelitis.	(111) (11111111111111111111111111111111				
	-11/5/12 Client #	# 1 was still in hospital.				
		ed "Update report on				
		vital signs) WNL (within				
	· ·	Lung sounds clear				
		d a CXR (chest xray),				
		. He is having daily				
		s done to his right foot"				
	diessing change	o done to mo ngm 100t				
	-11/12/12 Client	#1 had been transferred				
		tal. The note indicated				
		ray and bone scan were				
	anounci chest Al	ay and bone scan were				

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G699	A. BUILDING 00 COMPLETED 01/25/2013				
		150099	B. WIN			01/25/2	:013
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC, THE			LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRE			(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		e. The note indicated	+	TAG	DEI IOLERO I I		DATE
	~ ~						
	"He is getting dressing changes to his right foot. Consumer in the hospital duration is not known @ (at) this time."						
	duration is not k	nown (a (at) tins time.					
	-11/15/12 "Receiving wound care to RT foot daily. He remains in hospital						
	duration (sic)unl	•					
	(01 0)uiii						
	-11/20/12 "Co	onsumer remains on IV					
		BT (antibiotic) Rocefin					
	(sic) q (every) 24 hrs (hours). He receives						
	` ' * ` • '	care to both feet. the (sic)					
		s Aquacel AG (wound					
	~ ~	ys and on his left foot					
	(inner) Tegaderr						
	-11/23/12 Client	t #1 remained in the					
	hospital getting	IV antibiotics and					
	treatment to both	h feet.					
		continues to receive IV					
		ocefin (sic) every 24					
		ves wound care bilateral					
	,	nerapy continues to work					
	(with) this consu	ımer"					
		continues to receive IV					
		ocefin (sic) every 24 hrs.					
		ooth feet. No distress					
	noted."						
	12/2/12 "	ooing on IV fluids (ith)					
		nains on IV fluids (with)					
	continuous IV a	nuoioucs. Drsg					

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Event ID: 41PC11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
		15G699	B. WIN			01/25/	2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	IANA INC. THE			AYES ST LLVILLE, IN 46410		
				<u> </u>			(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE		DATE
	(dressing) care to	o Rt foot wound and Lt					
	(left) foot care n						
	(1010) 1000 0010 11	- C-					
	-12/10/12 "Repo	ort received on consumer					
	•	ell (sic). VS WNL. No					
		fluids and IV antibiotic					
	therapy. He take						
		therapy (PT) continues to					
		air. Wears bilateral boots					
	on both feet. Bil	lateral foot care done per					
	wound nurse. D	uration of hospital stay is					
	unknown @ this	time."					
	-12/14/12 "Repo	rt given that consumer					
	was doing good.	"					
	•	ort given consumer was					
		VS WNLContinues					
	1 '	re treatments. PT gets					
	1 1	o distress noted. Hospital					
	duration is unkno	own @ this time."					
	10/00/10 "						
		hospital quarterly nursing					
		completed on consumer					
	_	areas noted. Consumer					
		noted to right great toe					
		(with) Aquacel Ag and					
		to area and elevate foot					
		And apply Silvadene to					
		Aquaphor Oint (ointment)					
	to dry skin daily	" e Cumulative medical					
		the facility's nurse					
	neglected to doc	ument her 11/2/12					

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Event ID: 41PC11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G699	B. WIN	G		01/25/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					AYES ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e client when she went to					
		The above mentioned					
		he facility neglected to					
		up and/or document any					
		g assessments of client					
	#1's wound and/	or care, since the client					
	returned to the g	roup home on 12/22/12.					
		3 Confidential Medical					
		pital records indicated					
		mitted to the hospital on					
	1/7/13 for Urina	ry Retention. The					
	hospital records	indicated client #1 had an					
	assessment of the	e wound, on his right					
	foot, while the cl	lient was in the hospital.					
	The 1/9/13 medi	cal record indicated on					
	1/8/13, "Assess	sment completed. Patient					
	has dry eschar to	the right lateral foot.					
	Recommendation	ns to leave OTA (open to					
		ue to follow as needed.					
	· /	asures ordered." The					
		nt indicated the wound					
		d on 1/7/13 and was					
		The 1/8/13 note indicated					
	^ ~	d on the right foot was 1					
		in length and 1 cm in					
	width with "Atta	_					
	widii wilii Alla	onou ougos.					
	Client #1's 1/9/1	3 Discharge medications					
		#1 was to receive					
		ulcer/wound care)					
	`	topically 3 times daily"					
		in protectant) cream to					
	affected areas as	-					
	affected afeas as	unceteu.					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G699	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 01/25	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6101 HAYES ST MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	the facility neglethe Xenaderm as Cumulative Medifacility neglected information in the indicated why the being applied as Client #1's 8/27/Plan (ISP) indicated the facility of the indicated why the being applied as Client #1's 8/27/Plan (ISP) indicated the facility of the Xenamers of the indicated the facility of the Xenamers of the	Record (MAR) indicated beted to start and/or apply a ordered. Client #1's lical Record indicated the ditto document any se client's record which the Exercise Exercis					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE :	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G699	B. WIN	G		01/25/	2013
NAME OF P	PROVIDER OR SUPPLIER	\ \			ADDRESS, CITY, STATE, ZIP CODE		
					AYES ST		
ARC OF	NORTHWEST INDI	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	tion with the Xenaderm.					
		have asked pharmacy to					
		." LPN #1 indicated she					
		Medicaid would pay for					
		LPN #1 stated the					
		expensive." LPN #1					
		led to document the need					
		ation from the pharmacy					
		PN #1 indicated the					
		or medication had not					
		arted as of 1/15/13 at					
		asked if the LPN had					
		1's foot/ankle since					
		1 stated client #1 no					
	longer had an op	en area as the client had a					
	"scab" on the sid	le of his great right toe					
	and his left ankle	e was "back to normal					
	with a pea size s	cab." LPN #1 indicated					
	there was no doc	cumentation of her					
	assessments. PC	C#1 and/or LPN #1 did					
	not indicate the	elient's 7/2012 risk					
	plan/protocol had	d been reviewed and/or					
	updated to meet	client #1's current					
	healthcare needs	in regard to his					
	wound/skin brea	kdown.					
	Interview with th	ne DON on 1/15/13 at					
	2:45 PM indicate	ed LPN #1 had been					
	giving her update	es on client #1's wounds					
		N #1 indicated the LPN					
	should have doci	umented her assessments					
	of the client.						
	The facility's pol	licy and procedures were					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G699		LDING	NSTRUCTION 00	(X3) DATE COMPL 01/25	ETED
	PROVIDER OR SUPPLIER		p. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CODE AYES ST LVILLE, IN 46410	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	facility's 2/15/12 For Handling Ca Abuse indicated Indiana prohibits exploitation of o 2/15/12 policy ir defined as failure for the safety or anticipate and re client in a situati his/her health an include, but are re client of food, dr shelter, use of ba medical care/trea 3. The facility's were reviewed o The facility's 2/1 Policy For Hand and Abuse indica Northwest Indian neglect and expl clientsAll inve neglect, humiliate be investigated p Indiana's investigated p Indiana's investigation, investigations fo	policy and procedures n 1/14/13 at 11:42 AM. 5/12 policy entitled ling Cases Of Neglect ated "The ARC na prohibits all abuse, oitation of our stigations of abuse, cion or exploitation will ber The ARC Northwest gation process, while					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G699	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 01/2	TE SURVEY PLETED 25/2013			
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIE	P CODE				
ARC OF	NORTHWEST IND	IANA INC, THE	6101 HAYES ST MERRILLVILLE, IN 46410						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE			
	W154.								
	W154. 9-3-2(a)								

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		15G699	B. WIN			01/25/2013	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				AYES ST		
ARC OF	NORTHWEST INDI	ANA INC, THE			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0154	The facility must I alleged violations investigated. Based on record 3 of 8 incidents of injuries of unknown involving 2 of 4 group home (clief facility failed to	ents #2 and #3), the provide evidence of an d/or conduct thorough	Wo	154	All suspected abuse and or neglect incidents will be investigated thoroughly. Servic Coordinator will be re-trained of February 20 during annual training. New Nurse will be properly trained on reporting.		02/24/2013
	Findings include	:					
	this group home	investigation records for was made on 1/14/13 at investigation records for review.					
	Developmental I (BDDS) reports facility's adminis at 12:15 P.M R	facility's internal t reports and Bureau of Disabilities Services was conducted at the strative office on 1/14/13 Review of the facility's t and BDDS reports					
	"Client went into and banged head	dated 8/19/12 [Client #2]: behavior and ran outside against brick wall of Received a phone call					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G699	B. WIN	G		01/25/	2013
NAME OF I	PROVIDER OR SUPPLIER	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
					AYES ST		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	ct Support Professional)					
	_	r was having behaviors					
		the wall. I told DSP to					
	_	pply triple antibiotic					
		consumer that evening at					
	the house (sic) n						
		inch scratch, no further					
		o documentation was					
		iew to indicate the facility					
		thorough investigation of					
	the incident of p	ossible neglect.					
	_	dated 10/10/12 [Client					
	1 -	f walked to the back to					
		(sic) She found client on					
	the floor behind	the bed, which caused a					
	bruise on the rig	ht arm from bed rails.					
	_	right arm. Part B:					
	•	e call from group home					
	DSP stated clien	t was found on floor					
	behind the bed a	nd his right arm had a					
	bruise from the l	ped rail. Advised to					
	monitor consum	er often during the night					
	in order to preve	ent this from happening					
	again." No doc	umentation was available					
	for review to ind	licate the facility had					
	conducted a thor	ough investigation of the					
	unknown injury/	possible neglect incident.					
	BDDS report da	ted 10/10/12 [Client #3]:					
	"I was informed	by the Health and Safety					
		consumer (client #3) had					
		len out of his bed this					
	morning. Consu	imer received a bruise on					

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	of correction identification number: 15G699	(X2) MULTIPLE CO. A. BUILDING B. WING	00	COMPI 01/25	LETED		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6101 HAYES ST MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
IAU	his right arm." A review of client #3's record was conducted on 1/15/13 at 12:35 P.M Review of client #3's medical record indicated: Medical notation dated 7/20/12: "Informed by [Licensed Practical Nurse name] that she received a daily log from the house stating client (client #3) had a scratch 'by his left eye, of unknown origin.' Called and spoke to Health and Safety Tech, she assessed client and scratch. No scratch noted above, near or under left or right eye. Service Coordinator (SC) notified." No documentation was available for review to indicate the facility had conducted a thorough investigation of the unknown injury. An interview with the SC was conducted at the facility's administrative office on 1/15/13 at 2:10 P.M The SC indicated these incidents were not investigated to rule out neglect/abuse. The SC stated "I was told there were no investigations for this group home."	IAU			DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETE				
		15G699	B. WINC	·		01/25/	2013
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
ADC 05	NODELIMECT INC	NANA INC. THE			AYES ST		
	NORTHWEST INC	JIANA INC, THE		MERKII	LLVILLE, IN 46410		
(X4) ID			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION)	1	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
TAG W0207	REGULATORY OF 483.440(c)(2) INDIVIDUAL PR Appropriate facility failed for (client #2) to enparticipated in I (IDT) and Individual In	OGRAM PLAN ity staff must participate in team meetings. It review and interview, the or 1 of 2 sampled clients sure nursing staff interdisciplinary Team idual Support Plan (ISP) e: et #2's record was a facility's administrative at 11:30 A.M Review and 12/7/12 indicated hoses included, but were deizure Disorder, Impulse at Hydrocephalus (fluid in thunts (treats a Review of client #2's factors Assessment" dated and the det "Health: Diagnosed order or had new at taking more than one deizuresHas a psychiatric mently taking more than or psychoactive rrently taking one or more dications." Further cord failed to indicate reticipation in IDT	W02	TAG		nual sure d	02/24/2013
	meetings. No fi	urther documentation was					

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00		LETED
	15G699	B. WING		01/25	5/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	6101 H	ADDRESS, CITY, STATE, ZIP COD AYES ST LLVILLE, IN 46410	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPE DEFICIENCY)	LD BE	(X5) COMPLETION DATE
			CROSS-REFERENCED TO THE APPR	LD BE KOPRIATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	
		15G699	B. WIN	G		01/25/	2013
	ROVIDER OR SUPPLIER			6101 H	ADDRESS, CITY, STATE, ZIP CODE AYES ST LLVILLE, IN 46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	E	DATE
TAG W0227	483.440(c)(4) INDIVIDUAL PROTHE individual prospecific objectives client's needs, as comprehensive as paragraph (c)(3) of Based on observative record review for (#2), the client's (IDT) failed to acidentified behavior of the kitchen of the kitchen. Staff to put his shirt be client #1 was was with no shirt on it client had remove the kitchen count #2 on 1/15/13 at would remove his Staff #2 indicates plan for stripping Client #1's record 1/15/13 at 11:30 Individual Suppose behavior plan incomplete.	OGRAM PLAN ogram plan states the sencessary to meet the identified by the sesessment required by of this section. ation, interview and r 1 of 2 sampled clients interdisciplinary team ddress the client's foral need. 13 observation period of and 8:10 AM, at the ent #1 took off his shirt in eff #2 prompted client #1 ack on. At 6:34 AM, lking around the house in the living room. The ed his shirt and laid it on ter. Interview with staff 6:00 AM stated client #1 is clothes and "strip." d client #1 did not have a general strip of the control of the client #1 of the c	Wo		Client #1 behavior plan will be modified to include client taking his clothes off. To ensure futur compliance, ISP and behaviors plans will be assessed at annumeetings.	e al	02/24/2013

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G699			LDING	00	COMPL 01/25/	ETED	
	NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			6101 H	ADDRESS, CITY, STATE, ZIP CODE AYES ST LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	#1 on 1/15/13 at #1 would remov indicated client #	rogram Coordinator (PC) 1:50 PM indicated client e his clothes. PC #1 #1's ISP did not address ified behavioral training					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
		15G699	B. WIN			01/25/	2013
ARC OF	PROVIDER OR SUPPLIER	ANA INC, THE		6101 H	ADDRESS, CITY, STATE, ZIP CODE AYES ST LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
W0249	formulated a clier each client must in treatment program interventions and number and frequachievement of the individual program interview, and interview, the fact training objective opportunity for 1 (client #2) and fact #2's Behavior Suffindings included 1. A review of the incident/accident at the facility's and 1/14/13 at 12:15 reports indicated Incident report do #2] was in behavior and incident report do #2] was in behavior and incident report do go see and he the wall. I stopp slight scratch on	terdisciplinary team has nt's individual program plan, receive a continuous active in consisting of needed services in sufficient uency to support the ne objectives identified in gram plan. ation, record review, and cility failed to implement es during times of a of 2 sampled clients niled to implement client upport Plan (BSP). The facility's internal treports was conducted diministrative office on P.M Review of the atted 5/19/12: "[Client vior (sic) he was using. He went into the continued his disome booming. I went was hitting his head on the head a his head. Part B: Apply tent to the scrape on [client vior (client	W0	249	Group hom staff will be re-train on client's behavioral Plan, communication book and when and how to implement them to provide ongoing active treatmed Group home staff will be trained on client #2 diet (ground meat and chopped food)/To ensure future compliance, Service Coordinator will monitor twice monthly for 3 months and monthereafter.	n ent. ed	02/24/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G699	B. WING		01/25/2013
NAME OF P	PROVIDER OR SUPPLIEI	}	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
				AYES ST	
ARC OF NORTHWEST INDIANA INC, THE		MERRI	LLVILLE, IN 46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	PRIATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY	DATE
	T 11 4	1 . 1 0/10/12 . !!С!:			
	-	lated 8/19/12: "Client			
	` ′	into behavior and ran			
		ged head against brick			
		Part B: Received a phone			
	call from DSP (
		ting consumer was			
	_	s and hit head into the			
		to clean area and apply			
	triple antibiotic	ointment. I saw consumer			
	that evening at t	he house (sic) noted area			
	to be approxima	tely 1 inch scratch, no			
	further care need	ded. "			
	An evening obse	ervation at the group			
	home was condu	acted on 1/14/13 between			
	5:00 P.M. and 6	:15 P.M During the			
	entire observation	on client #2 walked			
	around the kitch	en area with no activity.			
	Direct Support I	Professionals (DSP) #1			
		se a communication			
	book/signs to co	mmunicate with client #2			
	_	ourage him to participate			
		inication during the entire			
	• 1	ient #2 did not and was			
		participate in fine motor			
	activities.	participate in fine motor			
	A facility owned	d day program observation			
	•	on 1/15/13 from 10:00			
		A.M During the entire			
		od client #2 sat in a			
	•				
	_	Day Program DSP #1			
	interacted with o	other clients in the room,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G699	B. WIN			01/25/2013	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
ADC OF	NORTHWEST IND	IANIA INIC. THE			AYES ST LLVILLE, IN 46410		
		·			LVILLE, IIN 404 IU		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E COMPLET DATE	ION
		act with client #2. Day	+	0		3.112	
		1, #2 and #3 did not use a					
	communication						
		th client #2 and did not					
		o participate in group					
	communication						
	observation.	3 .					
	A review of clien	nt #2's record was					
	conducted at the	facility's administrative					
		3 at 11:30 A.M A					
	review of client	#2's record indicated he					
	was nonverbal.	Review of client #2's					
	Individual Suppo	ort Plan (ISP) dated					
	12/7/12 indicated	d the following: "Will					
	continue to work	with his communication					
	book using pictu	res and signsWill					
	participate in fin	e motor activities."					
	Review of client	#2's BSP dated 12/2012					
	to 12/2013 indic	ated: "Targeted					
	Behaviors: Self	Injurious Behaviors:					
	Hitting head with	h fist, head banging,					
	biting fistRunr	ning away: Rapidly					
		pting to leave an area in					
		g supervised[Client #2]					
	is to be encourage						
		books several times a day					
		racking sheet was					
	_	is purposeReactive					
		Injurious Behaviors:					
		[client #2] that his					
		propriate and that					
	_	is a much more effective					
	way of dealing v	with a problem. They					

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	OF CORRECTION OF CORRECTION 15G699	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/25/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	6101 H	ADDRESS, CITY, STATE, ZIP CODE AYES ST LLVILLE, IN 46410	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	should aid [client #2] in communicating his desires through using his communication bookRunning away: Occurs infrequently and is preventable by closely monitoring [client #2] while taking him outside. He does not tend to go far but may go quickly without regard to his own safety, so it is better to prevent though (sic) preventative monitoring." The facility did not implement client #2's BSP to prevent the above mentioned 8/19/12 incident in regard to monitoring. An interview with the Service Coordinator (SC) was conducted on 1/15/13 at 2:10 P.M The SC indicated staff should implement active treatment training objectives at all times of opportunity. The SC further indicated client #2's BSP should be followed at all times. 2. During the 1/15/13 observation period between 5:30 AM and 8:10 AM, at the group home, client #2 was non-verbal in communication in that the client did not speak. At 5:56 AM, client #2 signed eat to staff #2. Staff #2 stated to client #2, "I have already shaved you this morning." Staff #1 and #2 did not encourage client #2 to use a communication book and/or pictures. During the above mentioned observation period, client #2 walked around the group home eating a whole			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G699		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/25/2013	
	PROVIDER OR SUPPLIEI		6101 H	ADDRESS, CITY, STATE, ZIP CODE AYES ST LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	breakfast. The secut up client #2's staff #1 cut up a size pieces and geto eat at the table 1/15/13 observation walked around the laid on the couch and/or training, encourage the clear training and/or a 8:10 AM. Client #2's recons 1/15/13 at 11:30 Individual Supportient #2 had an range of motion communication Client #2's 12/12 had an objective skills activity which implement when training existed. Interview with FPM indicated climeat chopped for	ave the client for staff did not chop and/or s apple. At 7:10 AM, second apple into bite gave the apple to client #2 e. Also during the tion period, client #2 he group home and/or h without an activity Staff #1 and #2 did not lient to participate in any activity from 7:10 AM to an activity from 7:10 AM to activity			

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PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

00	(X3) DATE SURVEY COMPLETED 01/25/2013
DDRESS, CITY, STATE, ZIP CODE YES ST LVILLE, IN 46410	
PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
I	DDRESS, CITY, STATE, ZIP CODE YES ST LVILLE, IN 46410 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

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Event ID: 41PC11

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15G699 B. WING	01/25/2013
	TY, STATE, ZIP CODE N 46410
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-RE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	VIDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
1 of 2 sampled clients (#1) with restrictive programs, the facility failed to obtain written informed consent from the client's guardian in regard to the client's client #1 signed b future co Coordinates signature	Coordinator will have ISP and Support Plan y his guardian. To ensure mpliance, Service ator will obtain guardian e at the annual meeting the allotted time frame.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPI	
		15G699	B. WING		01/25	/2013
NAME OF I	PROVIDER OR SUPPLIER	3		T ADDRESS, CITY, STATE, ZIP CODI	Ξ	
ARC OF	NORTHWEST IND	IANA INC, THE		HAYES ST RILLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	PROVIDER'S PLAN OF CORRECTION	
PREFIX	``	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION
W0268	#1's sister was the PC stated "She (not send stuff bathe client's guard #1's restrictive punct able to locate consent from the 9-3-4(a) 483.450(a)(1)(i) CONDUCT TOW These policies are promote the growindependence of Based on observe facility failed for (#2), to promote they were shave Findings included An evening obset the group home P.M. until 6:15 lobservation client An interview with Coordinator (SC)	ARD CLIENT and procedures must with, development and the client. The action and interview, the result of 2 sampled clients their dignity by ensuring decreased. The action was conducted at the action 1/14/13 from 5:00 P.M During the entire at #2 was unshaven. The service Procedures was conducted on P.M The SC indicated	W0268	Service Coordinator will regroup home staff on shave client #2.To ensure future compliance, Service Coor will monitor twice monthly months and monthly there	ing dinator for 3	02/24/2013

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AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBER: 15G699	A RIIII	DING	00	COMPL	ETED
		150600	A. BUILDING COMPLETE			ETED	
	100000		B. WING			01/25/	2013
NAME OF DRA	OVIDED OD GUDDI IED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PRO	OVIDER OR SUPPLIER			6101 H	AYES ST		
	IORTHWEST INDI			MERRIL	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0318	483.460 HEALTH CARE S The facility must e care services reques assed on observate record review, the Condition of Care Services for (#1 and #2) and for (#3). The facility's to meet the health clients it served. Services failed to address clients' health facility's health consure all staff which implemented clients it served as record assessments, and completed record appointments. Findings includes the facility's failed to ensure the services met the facility's failed to ensure the services met the facility's failed to ensure the services met the facility in regard to the clients in	services ensure that specific health direments are met. ation, interview and e facility failed to meet Participation: Health a 2 of 2 sampled clients for 1 additional client 's nursing services failed th care needs of the The facility's health care assess, monitor and/or ealth care needs, and facility staff were trained th needs of clients. The are services failed to the retrained and/or ents' risk plans according facified health needs to the was provided. The are services failed to ations were administered facted quarterly nursing for ensured a client famended doctor	W03		This client's risk plan for the use of a Foley Catheter was revise and then discontined. Upon the discontinuation of the catheter 1/16/13. Staff training was not completed as the catheter was discontinued. The nurse mana has written guidelines put in pl for the use of foley drainage equipment. The client is no lon using a foley catheter. Wound tracking and repositioning recordare in place. To ensure future compliance, staff will be trained as needed. Investigations will conducted if neglect is suspected to make the client's injuiry/skin breakdown within 24 hours of report. A new procedure has been put in place to identify the clients who are at risk for pressure ulcers across the boarnew repositioning sheets, wou tracking sheets, and quarterly's nursing review sheets have be developed. There are new questions on the quarterly nurs review sheet to identify those clients who need to be closely monitored for pressure ulcers. Client #3 medicaid was inactive, the physicians which was supposed to see would not allow an appointment to be scheduled. Since this point clie #3 medicaid has been activate and appoinments have been	de e on se ger acce ager ords de ted. Il osse ard, ld se len sing	02/24/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		15G699	B. WIN			01/25/2013	
NAME OF F				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	<u>t</u>		6101 HAYES ST			
	NORTHWEST IND				LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	scheduled. To ensure future	DATE	
		btained a physical			nr		
	examination. The facility's health care				compliance, a lead Coordinato position was developed to	"	
		ensure the facility's			oversee all client medicaid		
	nursing services	ensured staff called a			eligibility issues. By ensuring		
	nurse when a cli-	ent's health status			eligibility, future medical		
	changed, updated a client's risk plan for a Foley Catheter, and to ensure staff were adequately trained in regard to the care and use of the Foley Catheter. The facility's health care services failed to				appointments will be made. The	ne	
					system for monitoring the completion of quarterly nursing	,	
					assessments has been		
					updated.To ensure future		
					compliance, the Service		
	assess, monitor and/or address a wound on a client's ankle/foot for clients #1, #2				Coordinator will check this		
					tracking sheet to ensure all clie quarterly's assessments are	ents	
	and #3. Please s	· · · · · · · · · · · · · · · · · · ·			completed in a timely		
	and #3. Tiease s	CC W 551.			manner.Staff training was not		
	2 Th. C. 114 h.	1 1/1			completed as teh catheter was	3	
	I -	health care services			discontinued. The nurse mana		
		follow up exams were			has written guidelines put in pl	ace	
	_	commended by the			for the use of foley drainage equipment. The client is no lor	ngor	
		ient #3. Please see			using a foley catheter. Wound	igei	
	W322.				tracking and repositioning reco	ords	
					are in place.To ensure future		
	3. The facility's	health care services			compliance, staff will be traine		
	failed to have qu	arterly nursing			as needed. Investigations will	be	
	assessments com	pleted in a timely fashion			conducted if neglect is suspected.The group home sta	aff	
		d #2. Please see W336.			will be re-trained on medication	I	
					administration. To ensure future		
	4. The facility's	health care services			compliance, Service Coordina	tor	
		staff were adequately			will monitor twice monthly for 3		
					months and monthly thereafter	r.	
	trained in regard to client #1's Foley Catheter. Please see W342.						
	Cameter. Flease	300 W J42.					
	5. The facility's health care services						
		ster client #2's medication					
	without error. P						
	without error. P	lease see w 309.					

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PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G699	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 01/2	TE SURVEY TPLETED 25/2013		
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6101 HAYES ST MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	9-3-6(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G699		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/25/2013			
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6101 HAYES ST MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
W0322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview, the facility failed to assure 1 of 4 clients, residing at the group home, (client #3) had follow up exams as recommended by the physicians. Findings include: A review of client #3's medical record was conducted on 1/15/13 at 12:35 P.M Client #3's record indicated: Notation dated 5/2/12: "Client insurance inactive SC (Service Coordinator) made aware, will reschedule lab drawn when insurance is active." Notation dated 5/31/12: "Client had Pod. (podiatrist) appointment today (sic) insurance inactive will reschedule appointment once insurance is active. SC is aware of client insurance being inactive." Notation dated 6/21/12: "Chemical basis drawn at [Lab name] results pending due to inactive insurance. SC notified of the client insurance." Notation dated 7/27/12: "Physical	W0322	Client #3 medicaid was inactivated physicians which he was supposed to see would not all an appointment to be scheduled. Since this point client #3 med has been activated and appointments have been scheduled. To ensure future compliance, a Lead Coordina position was developed to oversee all client. Medicaid eligibility issues. By ensuring eligibility, future medical appointments will be made.	low led. icaid			

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Event ID: 41PC11

Facility ID: 003132

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G699		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/25/2013	
	PROVIDER OR SUPPLIEI NORTHWEST IND		6101 H	ADDRESS, CITY, STATE, ZIP CODE AYES ST ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		ion at [Hospital name] e to there was no			
	procedure at [Ho	8/6/12: "The Gastroscopy ospital name] was medicaid ineligibility."			
	family leave the will be reschedu 2013." Further current annual p	2/17/12: "consumer on a refore his annual physical aled after January 4, review indicated a most hysical for client #3 was which indicated to return			
	at 2:10 P.M The medical appoint	th the Service (2) was conducted 1/15/12 the SC indicated the ments did not happen urance was inactive for			
	9-3-6(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION				X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUII	A. BUILDING 00			COMPLETED	
		15G699	B. WIN			01/25	/2013	
NAME OF I	DROVADED OD GLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER			6101 H	AYES ST			
	NORTHWEST INDI			MERRILLVILLE, IN 46410				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG DEFICIENCY)			DATE		
W0331	483.460(c) NURSING SERV	ICES						
		provide clients with nursing						
	services in accordance with their needs.							
	Based on observ	ation, interview and	W0:	331	This client's risk plan for the use of a foley catheter was revised		02/24/2013	
	record review fo	r 2 of 2 sampled clients						
	(#1 and #2) and for 1 additional client (#3), the facility's nursing services failed to meet the health care needs of clients in regard to assessing, monitoring a client and then discontinued. Upo discontinuation of the cathe 1/16/13. Staff training was recompleted as the catheter with discontinued. The nurse man discontinued. The nurse man discontinued.				•			
					discontinuation of the catheter on 1/16/13. Staff training was not completed as the catheter was			
			discontinued. The nurse mana	ger				
	_	l injury and to ensure a			has written guidelines put in pl	ace		
	_	physical examination.			for the use of foley drainage equipment. The client is no longer using a foley catheter. Wound			
Т		rsing services failed to						
	I	ed a nurse when a client's			tracking and repositioning reco	ords		
		nged, to update a client's			are in place. To ensure future			
		oley Catheter, and to			compliance, staff will be traine			
	_	e adequately trained in			as needed. Investigations will conducted if neglect is suspec			
		e and use of the Foley			Community Services Nurse will assess a client's injuiry/skin breakdown within 24 hours or			
	1 ~	·						
		-						
	· ·				1 .			
	would on a clief	it's afficie/100t.				ose		
	Diadia as in dada					ard.		
	Findings include	·			New repositioning sheets, wou	ıld		
	1. The facility's	reportable incident				en		
	-	-			developed. There are new			
	*	2			questions on the quarterly nur	sing		
	1	•						
		,			monitored for product diocid.			
	office after being seen by MD (medical							
	to the hospital. Consumer was a direct							
	and treatment of difficult urinating. He							
	doctor). Consumer was then direct admit to the hospital. Consumer was a direct admit to [name of Hospital] for evaluation				report. A new procedure has been put in place to identify th clients who are at risk for pressure ulcers across the box New repositioning sheets, wou tracking sheets, and quarterly nursing review sheets have be developed. There are new	ard. Ild een sing		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	00	COMPL	ETED
		15G699	B. WING	u		01/25/	2013
				REET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			AYES ST		
ARC OF	NORTHWEST IN	DIANA INC, THE			LVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	II	ID PROVIDER'S			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TA	۸G	DEFICIENCY)		DATE
	had a stat bladd	ler scan done for urinary					
	retention. Fole	y catheter was put into					
	place to relieve	pressure of consumer's					
	bladder. He rei	mains in the hospital (sic)					
		nown at this time."					
	duration is unknown at this time.						
	Client #1's reco	ord was reviewed on					
	Client #1's record was reviewed on 1/15/13 at 11:31 AM. Client #1's 1/8/13						
	_	lential Medication					
		closed record indicated					
		dmitted to the hospital as					
		not urinate on 1/7/13. The					
		client #1 was discharged					
	_	up home with a Foley					
	Catheter.						
	The 1/7/13 Uro	logy Consult Note					
	indicated "Reas	son for Consult chronic					
	urinary retention	on in this patient with a					
	-	ve/vein) dementia, Down					
	syndrome and s	-					
	*	ssment 1. the patient was					
		icute chronic urinary					
		ne renal function					
		mal (sic). He has a history					
	*	own's syndrome and					
		er outlet obstruction. Plan					
	` ,	onsider cystoscopy and					
	1	ight laser photo selective					
vaporization of the prostate. Additional							
	recommendation	ons to follow."					
	Client #1's 1/7/	13 Bladder Volume Echo					
indicated "Mild thickening of the							

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G699	(X2) MULTIPLE A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 25/2013
	PROVIDER OR SUPPLIEF		STREE 6101	T ADDRESS, CITY, STATE, ZII HAYES ST RILLVILLE, IN 46410	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
		h sludge within the The patient did not void				
	indicated client and 1/9/13 and return The discharge sufficient was to return urinary retention summary indicated Instructions "Doweek, if unable to and call [name of number]"	C				
	to no urinary our client #1 was ex fullness with dis note indicated cl diagnosed the cl Retention" and c (immediate) blace -1/14/13 "Late E home to check o signs) stable. As	ient with "Urinary ordered a STAT				
	urinary bladder. for this exam." Client #1's 1/9/1 indicated client #1/9/13 and return. The discharge su #1 was to return urinary retention summary indicated instructions "D/week, if unable to and call [name on number]" Client #1's Cumnotes indicated to inclusive): -1/7/13 Client #1 to no urinary our client #1 was exfullness with disnote indicated with a was exfulln	The patient did not void 3 Discharge Summary #1 was discharged on med to the group home. Immary indicated client to the doctor for his in. The discharge ted "Discharge ted "Discharge to urinate insert 16f foley of doctor] on [phone ulative Medical Record he following (not all I saw his doctor in regard the true that the medical inent #1's doctor in the medical inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary ordered a STAT inent #1's doctor inent with "Urinary or				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G699	B. WIN	G		01/25/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					AYES ST		
ARC OF	NORTHWEST INDI	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	`	N #1) advised staff to					
	take him to the [name of hospital]						
		was taken to the ER					
		n) and new orders					
		Dx (diagnosis) of					
	Encounter for Foley Catheter replacement						
	and UTI (Urinary Tract Infection) and						
	medication and new medications orders						
	received (sic). H	Ie will be seen by his					
	urology doctor n	ext week, Labs will be					
	done on 1/15/13. Will continue to						
	monitor consum	er." Client #1's above					
	mentioned medic	cal record, which					
	included the nurs	se notes, indicated the					
	facility's nurse fa	ailed to assess the client					
	when he was dis	charged from the hospital					
	on 1/9/13, to ens	ure facility staff					
	monitored the cl	ient and/or called the					
	facility nurse wh	en client #1's health					
	status changed.						
	Client #1's 1/8/1	3 Health and Safety					
) from LPN #1 was					
	` -	viewed on 1/15/13 at 3:45					
		indicated the following:					
		· · · · · · · · · · · · · · · · · · ·					
	"Instructions for	catheter care:					
	-Keen the hag he	elow the waist at all times					
		hung on the frame of the					
	_	t CANNOT be placed on					
	the floor	it of it to the placed off					
		ubber tubing is 'free of					
		s'-Empty the bag into the					
	KIIIKS at all tillles	5-Empty the bag into the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED
		15G699	B. WIN	G		01/25/2013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					AYES ST	
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		*		TAG	DEFICIENCY)	DATE
	white basin befo	•				
	-Measure the amount of urine using the					
		sin and record it on the I				
		e & output) sheet daily				
	I -	wash your hands before				
	and after emptying the catheter and wear					
	gloves while handling the urine bag					
		ine output in 4 hours call				
	your nurse imme	ediately				
	Instructions for leg bag:					
		plastic tubing from the				
	catheter bag					
	-Connect the tub	ing to the leg bag				
	-Position the bag	g on the inside of the leg				
	with the straps a	bove and below the knee				
	-Adjust the strap	s for a comfortable fit				
	-Make sure the s	traps are not too tight and				
	cutting off circul	ation				
	-The leg bag is to	o be worn only during the				
	day					
	-Empty the leg b	ag every 2 hours as				
	needed and recor	rd the output on the I & O				
	sheet					
	-If there is no ur	ine output in 4 hours call				
	your nurse imme	ediatelyS/S (Signs and				
	Symptoms) for a	client with a Foley:				
	1. Temperature	greater than 101				
	2. Persistent nau	usea and vomiting				
	3. Redness, tend	lerness, or signs of				
	· ·	welling, redness, odor or				
		charge around site				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		15G699	B. WIN	G		01/25/2013
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					AYES ST	
ARC OF	NORTHWEST INDI	IANA INC, THE		MERRIL	LVILLE, IN 46410	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	4. Severe uncor	•				
	5. Difficulty breathing, headache or					
	visual disturbanc	ce				
	6. Hives					
	7. Persistent hea	adaches or visual				
	disturbance					
	8. Extreme fatigue					
	9. Difficulty with or inability to urinate					
	10. Any other co	oncerns call nurse."				
	Client #1's hospital records were reviewed					
	on 1/15/13 at 2:45 PM. The 1/12/13					
	Emergency Depa	artment note indicated				
	client #1's diagno	oses included, but were				
	not limited to, "I	Encounter for Foley				
	catheter replacer	nent" and UTI, site not				
	_	/12/13 note indicated				
	_	rted on Levaquin				
		milligrams 1 tablet daily,				
		wder apply three times a				
	· ·	The ER note indicated a				
	1 -	welling Bladder Catheter				
		laced in the client's				
		12/13 ER note had				
		structions attached to the				
		ctions indicated "You can				
		f infection if you:				
	10ddoc die 115k 0	i iiioonoii ii you.				
	I imit the numb	er of germs (bacteria)				
	entering your bla	- · · · · ·				
	ontering your ord	iddor.				
	-Protect the tissu	e from injury				
	-1 Total tile tissu	ic nom mjury.				
	-Keep the urinar	y pathways				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G699		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	COI	TE SURVEY MPLETED 25/2013	
		15G699	B. WING			25/2013
	PROVIDER OR SUPPLIER		6101 H	ADDRESS, CITY, STATE, ZIP HAYES ST ILLVILLE, IN 46410	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	openFOLLOW TO LIMIT THE BACTERIA EN BLADDER					
	-Wash your hands for 2 minutes with soapy water before and after handling the catheter. -Wash the perineal area and entire length of the catheter twice daily and after each bowel movement. Wash urethral opening and catheter with soap and warm water, rinse, and then wash the rectal area. Always wash front to back.					
	reverse, cleanse where it connect	the leg bag to bed bag or the end of the catheter s to the tubing. Do this corously with an alcohol				
	daily after use.	nd night drainage bags Replace your drainage when you can no longer them.				
	below the level of allow urine to dr Lifting the bag of of your bladder of (contaminated) u	bing and collection bag of your bladder. This will ain properly by gravity. It tubing above the level will cause unclean urine to flow back into you must momentarily				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G699	B. WIN			01/25/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
4DC OF	NODEL IMPORTANTO	IANIA INC. THE			AYES ST		
	NORTHWEST INDI			MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		IAU			DATE
	"	er than your bladder, such					
	as turning from side to side, pinch the						
	catheter or tubing to prevent back-flow.						
	Drink at loagt 6	9 alogges of water daily					
		-8 glasses of water daily. acteria out of the					
		Catheter care instructions					
		tions to protect tissues					
		njured and how to keep					
		vay open. The facility					
	J 1	nediately update the					
	~	to incorporate all of the					
	_	endations to prevent					
		•					
	chent #1 from po	otential infections.					
	The facility's ins	ervice/training records					
		n 1/15/13 at 1:12 PM.					
	The facility's Sta						
		ing/Group Training					
		d LPN #1 trained staff #4					
		to client #1's Foley					
	_	e on 1/9/13. The					
		s indicated LPN #1					
		ce staff #6, #7, #8 and #9					
	1	facility's inservice					
		LPN #1 trained staff #3					
		/13. The facility's					
		s indicated staff #5					
		on 1/14/13 but LPN #1					
		iner. The facility's 1/9,					
	_	/14/13 inservice training					
	· ·	I the facility's nursing					
		train staff #11 and #12					
	in regard to cher	nt #1's Foley Catheter and					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G699	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00		SURVEY LETED 5/2013
	PROVIDER OR SUPPLIER		S. W.I.V.	STREET A	DDRESS, CITY, STATE, ZIP CO AYES ST LVILLE, IN 46410	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
IAU	care. The facility to ensure facility trained in regard #1's risk plan/hea informed the nur Foley catheter/cl During the 1/15/between 5:30 AM group home, staff at the Interview with staff at the staff	y's nursing services failed staff were adequately to implementing client alth memo to ensure staff se of changes with the ient's health. 13 observation period M and 8:10 AM, at the ff #2 worked as the night e group home.		IAU	B. C.E.C.)		DATE
	Catheter. Staff # in regard to the compared to	tent #1 had a Foley #1 stated she was trained #2 stated she was trained #3 stated she was trained #4/13). Staff #1 indicated wacation. When asked if ten protocol, staff #1 #1 not know. Staff #1 was #2 a written #1 was the a written					
	#1 and LPN #1 of indicated client # for urinary retended client #1 was diston 1/9/13 or 1/10 client #1 saw his was admitted to LPN #1 indicate.	rogram Coordinator (PC) on 1/15/13 at 1:50 PM #1 had been hospitalized tion. LPN #1 indicated charged from the hospital 0/13. LPN #1 indicated doctor on 1/7/13 and the hospital on 1/7/13. d she assessed the client rday) when she had the					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G699	B. WIN	G		01/25/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					AYES ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		MERRIL	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ER. LPN #1 stated she					
	11 5 0	roup home to check on					
		he noticed client #1's					
	penis was "swoll	en, red with pus coming					
	out of penis." L	PN #1 stated "They					
	(facility staff) di	d not call me. They					
	should have calle	ed." LPN #1 and PC #1					
	indicated facility	staff were trained in					
	regard to the care	e of the Foley Catheter					
	and when to call	the nurse. PC #1 and					
	LPN #1 indicate	d they were not aware					
	staff #11 and #12	2 had not been trained in					
	regard to client #	[‡] 1's Foley Catheter.					
	When asked if cl	•					
	protocol/risk pla	n for the Foley Catheter,					
		have not seen one. In					
		g or re-writing." LPN #1					
	•	rector of Nursing (DON)					
		a policy and procedure					
		theter and the DON was					
	_	olan for the catheter.					
	writing the risk p	null for the eatheter.					
	Interview with th	ne DON on 1/15/13 at					
		-					
		• .					
		_					
		•					
	Foley Catheter c	are.					
	PM indicated the	e memo for client #1's					
	Interview with the 2:45 PM indicates been written and home. The DON #1 was not award. The DON indicates process of updates and developing a Foley Catheter continued in the process of the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley Catheter continued in the process of updates and developing a foley continued in the process of updates and developing a foley continued in the process of updates and developing a foley continued in the process of updates and developing a foley continued in the process of updates and developing a foley continued in the process of updates and developing a foley continued in the process o	ne DON on 1/15/13 at ed a memo/protocol had sent out to the group I did not know why LPN e of the memo/protocol. ted she was in the ing the protocol/memo a policy and procedure for					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G699	B. WING		01/25/2013
NAME OF E	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CODE	
				AYES ST	
ARC OF	NORTHWEST IND	IANA INC, THE	MERRI	LLVILLE, IN 46410	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	The state of the s	was found/located in the			
		book at the group home			
	on 1/15/13 at 3:4	46 PM.			
	Interview with a	administrative staff #3 on			
		PM, by phone, indicated			
		worked on 1/12/13			
		client #1 at the group			
	home. Adminis	trative staff #3 indicated			
	· ·	#10 worked on 1/11/13			
		roup home. The above			
	mentioned inser	vice/training records			
	indicated staff #	3, #5 and #10 had been			
	trained in regard	l to client #1's Foley			
	Catheter protoco	ol/risk plan, but failed to			
	call the nurse in	regard to client #1's			
	health status cha	ange.			
	2. The facility's	reportable incident			
	reports and/or in	ivestigations were			
	*	4/13 at 12:03 PM. The			
		ble incident reports			
	indicated the fol	_			
		5			
	-11/2/12 "I (LPN	N #1) received a phone			
	· ·	mer (client #1) having a			
		ner left ankle that had			
		an open sore. I asked if			
		l intact (sic)staff replied			
		taff to apply triple			
	-	ent to the area and cover			
		The blister breaks, a loose			
	_	hang over the wound.			
	_	•			
	Oniess uns skin	is dirty or has pus			

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 15G699	(X2) MULTIPLE CO A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 01/25/2013				
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6101 HAYES ST MERRILLVILLE, IN 46410						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODECTION OF THE PROPERTY OF THE APPROPRIES OF THE APP	D BE COMPLETION				
	developing underneath, leave it alone since it will keep the wound protected. After a few days, it is safe to gently cut away the dead skin. I went to the house to see this consumer and staff showed me that the dead skin had come off. I advised staff to apply the same treatment and that I will get him into the doctor as soon as possible. Consumer seen by [name of doctor] today and consumer was sent to the hospital as a direct admit for Sepsis Syndrome (infection bloodstream), Right Cellulitis (skin infection) with Osteomyelitis (bone infection)." The facility's 11/13/12 follow-up report indicated "Consumer (client #1) is in stable condition vital signs within normal limits. Chest X-ray and Bone Scan. He is having daily dressing changes to his right foot. Consumer will need long term care for Sepsis and is currently in the hospital." -11/9/12 "[Client #1] has been transferred from [name of hospital] to [name of hospital] to [name of hospital] for further treatment of Sepsis and Pneumonia. He remains in the hospital duration (sic) of stay is unknown at this time." Client #1's record was reviewed on							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G699		A. BUII	LDING	NSTRUCTION 00		SURVEY LETED 5/2013	
		130033	B. WIN		DDDDGG GWYL GWLWE GW		72013
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COI AYES ST	DE	
ARC OF	NORTHWEST INDI	ANA INC, THE			LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		AM. Client #1's					
		lical Record (nurse and					
	doctor notes) not						
	following (not al	l inclusive):					
	-11/2/12	‡1 was seen by his doctor					
		listers. The 11/2/12					
	~	icated client #1 was					
		Ft (foot) necrotic (dead					
		great toe and lateral					
	foot wound with foot cellulitis A						
	(Assessment):						
	(1) (R) Foot Cellulitis						
		eomyelitis with necrotic					
		sis SyndromeAdmit					
	with SS (Sepsis	•					
	with 55 (Sepsis	Syndrome).					
	-11/2/12 "Consu	mer was seen by [name					
	of doctor] today	for blister on his right					
	foot. He						
	was admitted to	[name of hospital] for					
	Sepsis Syndrome	e (RT) cellulitis (with)					
	Osteomyelitis.						
	11/5/12 (21: /	4.1 a4ill in 1 14-1					
		† 1 was still in hospital.					
		ed "Update report on					
	· ·	vital signs) WNL (within					
	· · · · · · · · · · · · · · · · · · ·	ung sounds clear					
		d a CXR (chest xray), He is having daily					
		s done to his right foot"					
	diessing changes	o done to ms right foot					
	-11/12/12 Client	#1 had been transferred					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL		
		15G699	A. BUI B. WIN	LDING		01/25/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF F	PROVIDER OR SUPPLIER				AYES ST		
ARC OF	NORTHWEST IND	ANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	_	al. The note indicated ay and bone scan were					
		The note indicated					
		dressing changes to his					
		umer in the hospital					
	_	nown @ (at) this time."					
	adiation is not k	no nii (w (ut) uns tiiic.					
	-11/15/12 "Red	ceiving wound care to RT					
		emains in hospital (sic)					
	duration unknow	• ` ′					
-11/20/12 "Consumer remains on IV							
	(intravenous) AI	BT (antibiotic) Rocefin					
	(sic) q (every) 24	4 hrs (hours). He receives					
	bilateral wound	care to both feet. the (sic)					
	right foot he gets	s Aquacel AG (wound					
	care) every 3 day	ys and on his left foot					
	(inner) Tegadern	n"					
	11/02/12 (1: /	//1 · 1 · /1					
		#1 remained in the					
		IV antibiotics and					
	treatment to both	i ieci.					
	 -11/27/12	continues to receive IV					
		cefin (sic) every 24					
		yes wound care bilateral					
		erapy continues to work					
	(with) this consu						
	() 1113 001130						
	-11/29/12 "He	continues to receive IV					
		cfin every 24 hrs.					
		oth feet. No distress					
	noted."						
							I

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G699	LDING	NSTRUCTION 00	(X3) DATE COMPI 01/25	LETED
	PROVIDER OR SUPPLIER		6101 HA	DDRESS, CITY, STATE, ZIP CODE AYES ST LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	-12/3/12 "Rem continuous IV ar (dressing) care to (left) foot care not -12/10/12 "Report he was doing we long (sic) on IV therapy. He take orallyPhysical get him up to char on both feet. Bil wound nurse. Dunknown @ this -12/14/12 "Report was doing good12/18/12 "Report doing very well. (with) wound car him up daily. No	ains on IV fluids (with) ntibiotics. Drsg DRt foot wound and Lt oted" Ort received on consumer Ill (sic). VS WNL. No fluids and IV antibiotic es medication therapy (PT) continues to air. Wears bilateral boots lateral foot care done per uration of hospital stay is time."		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO) BE	
	assessment was a homeNo open has wound care is cleansed apply Tegaderm off bed surfaces. left ankle apply to dry skin daily	hospital quarterly nursing completed on consumer areas noted. Consumer noted to right great toe (with) Aquacel Ag and to area and elevate foot And apply Silvadene to Aquaphor Oint (ointment)"				

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G699	B. WIN	G		01/25/2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	
					AYES ST	
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		the facility's nurse failed				
		11/2/12 assessment of				
		she went to the group				
		re mentioned notes				
		ility's nursing services				
		r, follow-up and/or				
	document any ac	dditional nursing				
	assessments of c	lient #1's wound and/or				
	care, since the cl	lient returned to the group				
	home on 12/22/12.					
	Client #1's 1/9/13 Confidential Medical					
	Information hosp	pital records indicated				
	client #1 was add	mitted to the hospital on				
	1/7/13 for Urina	ry Retention. The				
		indicated client #1 had an				
	-	e wound, on his right				
		lient was in the hospital.				
	1	cal record indicated on				
		sment completed. Patient				
	·	the right lateral foot.				
	_	ns to leave OTA (open to				
		ue to follow as needed.				
	· /	asures ordered." The				
		nt indicated the wound				
		d on 1/7/13 and was				
		The 1/8/13 note indicated				
		d on the right foot was 1				
		in length and 1 cm in				
	width with "Atta	_				
	widui witii Alla	icheu euges.				
	Client #1's 1/0/1	3 Discharge medications				
		#1 was to receive				
		ulcer/wound care)				
	Achadeiii (SKII	i dicei/woulld cale)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G699	B. WIN	G		01/25/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					AYES ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	111	topically 3 times daily"					
	and "Eucerin (skin protectant) cream to						
	affected areas as directed."						
	Client #1's 1/13						
		Record (MAR) indicated					
		sing services failed to					
		y the Xenaderm as					
		#1's Cumulative Medical					
		I the facility's nurse failed					
		information in the					
		hich indicated why the					
		ot being applied as					
	ordered.						
	G1:	10 1 1 1 1 0					
		12 Individual Support					
	` ′	ated client #1 had a					
	•	protocol for Skin					
		e risk plan indicated					
		risk for skin breakdown.					
	_	ed "Staff should ask					
		his skin and do a visual					
		skin when practical.					
		ent on daily logs any					
	_	I fill out an incident					
	_	bleeding or openings are					
		2012 risk plan indicated					
	"Staff are to noti	fy the Community					
	Services Nurse i	f any changes in color,					
	redness, opening	s, or bleeding is					
	observed. He wi	ill have a doctor's					
	appointment sch	eduled or taken to the ER					
	if the sores are se	evere"					
	1						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G699	B. WIN			01/25/	2013
NAME OF I	PROVIDER OR SUPPLIE	ER .			ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST IND	DIANA INC, THE			AYES ST LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	REFERENCED TO THE APPROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION) 7/12 ISP and/or record		TAG	DLI ICILICI I		DATE
		cility's nursing services and or address client #1's					
		elient's feet/ankle to ensure					
		ent 7/2012 risk plan was					
		net the health care needs					
		he client's Medical					
		cord, ISP and/or record					
		te facility staff were					
		•					
	re-trained in regard to the client's wound care protocol to ensure the staff						
	monitored the client's skin and/or reported						
	any concerns to the facility's nurse.						
		the facility s harse.					
	Interview with	LPN #1 and PC #1 on					
		PM indicated client #1					
		hospital several times due					
		lical issues. LPN #1					
	indicated client	#1's hospitalization in					
		to the wound on client #1's					
	right foot. LPN	#1 indicated the client					
	_	d due to Sepsis. LPN #1					
	•	home staff called her and					
	she went to the	group home to assess the					
	blister. LPN #1	indicated she made a					
	doctor's appoin	tment for the client to be					
	seen and the cli	ent was taken to the doctor					
	on 11/2/12. WI	nen asked how client #1					
	received the wo	ounds to his feet, LPN #1					
	stated she had a	sked staff if the client's					
	"shoes were too	small." LPN #1 indicated					
	client #1 no lon	ger received Silvadene					
	cream to his wo	ounds. LPN #1 indicated					
	client #1 still w	ent to a wound clinic and					

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NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 6101 HAYES ST MERRILLVILLE, IN 46410 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE OATS DATE		NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G699	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPI 01/25	LETED
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY PROVIDERS PLAN OF CORRECTION (EACH CORRECTION (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE				p. White	STREET A	AYES ST	<u> </u>	
	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	(X5) COMPLETION DATE
was scheduled to go on 1/10/13 but the client did not go. LPN #1 indicated client #1's ordered Xenaderm had not been started. LPN #1 indicated she was seeking clarification with the Xenaderm. LPN #1 stated "I have asked pharmacy to send out consult." LPN #1 indicated she was not sure if Medicaid would pay for the Xenaderm. LPN #1 stated the Xenaderm was "expensive." LPN #1 indicated she failed to document the need to obtain clarification from the pharmacy and/or doctor. LPN #1 indicated the clarification and/or medication had not been obtained/started as of 1/15/13 at 1:50 PM. When asked if the LPN had assessed client #1's foot/ankle since 12/22/12, LPN #1 stated client #1 no longer had an open area as the client had a "seab" on the side of his great right toe and his left ankle was "back to normal with a pea size seab." LPN #1 indicated there was no documentation of her assessments. PC #1 and/or LPN #1 did not indicate the client's 7/2012 risk plan/protocol had been reviewed and/or updated to meet client #1's current healthcare needs in regard to his wound/skin breakdown. Interview with the DON on 1/15/13 at 2:45 PM indicated LPN #1 had been giving her updates to noin fleated the LPN #1 had been giving her updates to noin fleated the LPN #1 had been giving her updates to noin fleated the LPN #1 had been giving her updates to noin fleated the LPN #1 had been giving her updates to no client #1's wounds on his feet. DON #1 indicated the LPN		client did not go #1's ordered Xer started. LPN #1 seeking clarifica LPN #1 stated "I send out consult was not sure if N the Xenaderm. I Xenaderm was " indicated she fai to obtain clarific and/or doctor. I clarification and been obtained/st 1:50 PM. When assessed client # 12/22/12, LPN # longer had an op "scab" on the sid and his left ankle with a pea size s there was no doc assessments. PC not indicate the op plan/protocol ha updated to meet healthcare needs wound/skin brea Interview with th 2:45 PM indicate giving her updat	LPN #1 indicated client haderm had not been indicated she was tion with the Xenaderm. I have asked pharmacy to "LPN #1 indicated she Medicaid would pay for LPN #1 stated the expensive." LPN #1 led to document the need ation from the pharmacy LPN #1 indicated the for medication had not arted as of 1/15/13 at asked if the LPN had also foot ankle since as the client #1 no been area as the client had a le of his great right toe was "back to normal cab." LPN #1 indicated cumentation of her C #1 and/or LPN #1 did client's 7/2012 risk do been reviewed and/or client #1's current in regard to his kdown. The DON on 1/15/13 at eed LPN #1 had been ees on client #1's wounds					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G699	A. BUILDING B. WING		01/25/2013
			_	T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	ER		HAYES ST	
ARC OF	NORTHWEST IN	DIANA INC. THE		RILLVILLE, IN 46410	
	•			,	775
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD)	
PREFIX TAG	,	ONCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROF	
TAG		•	IAG		DATE
		cumented her assessments			
	of the client.				
	3. A review of the facility's internal				
		nt reports was conducted			
	1	administrative office on			
	1/14/13 at 12:1	5 P.M Review of the			
	reports indicate	ed:			
	Incident report dated 5/19/12: "[Client				
	#2] was in behavior he was screaming,				
	grunting. He w	vent into bathroom where			
	he continued hi	s behavior. I heard some			
		nt to go see and he was			
	_	on the wall. I stopped			
	_	a slight scratch on his			
		Apply antibiotic ointment			
		* * *			
	to the scrape of	n [client #2's] forehead. "			
	In aid ant man aut	datad 9/10/12: "Client			
	^	dated 8/19/12: "Client			
	` ,	t into behavior and ran			
		nged head against brick			
		Part B: Received a phone			
	call from DSP				
	· · · · · · · · · · · · · · · · · · ·	tating consumer was			
	having behavio	ers and hit head into the			
	wall. I told DS	P to clean area and apply			
	triple antibiotic	ointment. I saw consumer			
	that evening at	the house noted area to be			
	approximately	1 inch scratch, no further			
	care needed."				
	A review of cli	ent #2's record was			
		e facility's administrative			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G699	B. WIN	G		01/25/	2013
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					AYES ST		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		3 at 11:30 A.M Review					
	of client #2's medical record failed to						
		sing assessment by the					
	facility's nursing	staff after the 5/9/12					
	incident. The re	cord failed to indicate					
	measures were p	out in place to give staff					
	guidance on mor	nitoring client #2 for any					
	symptoms.						
	4. Incident Report dated 10/10/12 [Client						
	#3]: "When staff walked to the back to						
	check on clients.	(sic) She found client on					
	the floor behind	the bed, which caused a					
		ht arm from bed rails.					
		right arm. Part B:					
	•	e call from group home					
	_	t was found on floor					
		nd his right arm had a					
		ped rail. Advised to					
		er often during the night					
		ent this from happening					
	again."	in this from happening					
	agam.						
	RDDS report dat	ted 10/10/12 [Client #3]:					
		by the Health and Safety					
		consumer (client #3) had					
		len out of his bed this					
	_	imer received a bruise on					
	his right arm."						
	A ravious af alter	nt #3's record was					
		15/13 at 12:35 P.M					
		#3's medical record					
	indicated:						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G699	B. WIN	G		01/25/	2013
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					AYES ST		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	l `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
	N. 1. 1	1 / 17/20/12					
	Medical notation						
	"Informed by [Licensed Practical Nurse						
	name] that she received a daily log from						
	1	g client (client #3) had a					
	1	eft eye, of unknown					
	_	nd spoke to Health and					
	Safety Tech, she assessed client and						
	scratch. No scratch noted above, near or						
	under left or right eye. Service						
	Coordinator (SC) notified." Further						
		cord failed to indicate					
	_	ents were completed by					
	1	sing staff after the					
	documented inci	dents.					
		of client #3's medical					
	record indicated:	:					
		7/2/12: "Client insurance					
		e aware, will reschedule					
	lab drawn when	insurance is active."					
	Notation dated 5	/31/12: "Client had Pod.					
		intment today (sic)					
	insurance inactiv	ve will reschedule					
	appointment onc	ee insurance is active. SC					
	is aware of clien	t insurance being					
	inactive."						
	Notation dated 6	5/21/12: "Chemical basis					
	drawn at [Lab na	ame] results pending due					
	to inactive insura	ance. SC notified of the					
	client insurance.	"					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G699	B. WIN			01/25/2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
4DC 0E	NODEL IMPORTANTO	IANIA INIC. THE			AYES ST	
	NORTHWEST INDI	·			_LVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIF TING INFORMATION)		TAG	,	DATE
	Notation dated 7	//27/12: "Physical				
		•				
	Therapy evaluation at [Hospital name] was not done due to there was no insurance."					
	Notation dated 8/6/12: "The Gastroscopy					
	procedure at [Hospital name] was canceled due to medicaid ineligibility."					
	Notation dated 12/17/12: "consumer on a family leave therefore his annual physical					
	*					
		led after January 4, review indicated a most				
	_	hysical for client #3 was				
		which indicated to return				
	in 1 year.					
	A m imtomio	th the Licensed Practical				
	` ′	s conducted on 1/15/13 at nurse indicated there was				
		on available for review to				
		ing staff assessed client				
		banging incidents.				
		ne facility nursing staff 3 after each of the				
		s and noted injury of				
	I -	she stated "No." When				
		3 had a more current				
		she stated "No." When				
	1	t #3 did not go to the				
		ments, she stated "His				
	insurance was in	_				
	documentation w	vas submitted for review				

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Event ID: 41PC11

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PRINTED: 03/14/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15G699	A. BUILDING B. WING	00	COMPLETED 01/25/2013
	PROVIDER OR SUPPLIER		6101 H	ADDRESS, CITY, STATE, ZIP CODE HAYES ST ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
		cility's nursing staff g services for clients #1, mented medical			
	9-3-6(a)				

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Event ID: 41PC11

Facility ID: 003132

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G699	B. WIN			01/25/	2013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				AYES ST		
ARC OF	NORTHWEST INDI	ANA INC, THE			LLVILLE, IN 46410		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0336	•	ICES must include, for those s not needing a medical					
	which must be on	w of their health status a quarterly or more pending on client need.	Wo	226	The content for an air in the		02/24/2012
	D 1 1		W0.	030	The system for monitoring the	,	02/24/2013
		review and interview, the			completion of quarterly nursing assessments has been updated.		
		2 of 2 sampled clients			To ensure future compliance, t		
	(clients #1 and #2	*			Service Coordinator will check		
	conditions, to ha	ve quarterly nursing			this tracking sheet to ensure all		
	assessments com	pleted in a timely			clients quarterly's assessments		
	fashion.				are completed in a timely man	ner.	
	Findings include	:					
	1. A review of c	lient #2's records was					
	conducted on 1/1	15/13 at 11:30 A.M The					
	record review fai	iled to indicate the					
	quarterly nursing	g assessments had been					
		y. Client #2's quarterly					
		ents were dated 1/7/12,					
	•	/12. Further review of					
		l indicated he was not in					
		ll care plan and an annual					
		*					
		29/12. No further					
		vas available for review					
		#2 had a nursing					
	quarterly comple	eted after 7/13/12.					
	Nurse (LPN) was	th the Licensed Practical s conducted on 1/25/13 at e LPN stated "Nursing ald be completed					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G699	B. WIN			01/25/	/2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			AYES ST		
ARC OF	NORTHWEST IND	IANA INC, THE			LLVILLE, IN 46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	quarterly." No c	locumentation was					
	available for rev	iew in client #2's record					
	to indicate a qua	rterly nursing assessment					
	was completed after 7/13/12.						
	•						
	2. Client #1's record was reviewed on						
	1/15 13 at 11:31 AM. Client #1's						
		g assessments were dated					
	· ·	and and 12/22/12.					
		t have any additional					
		ments in his record.					
		12 Individual Support					
	Plan indicated cl	lient #1 did not need a					
	medical care pla	n. Client #1's 1/13					
	Medication Adm	ninistration Record					
	indicated client	#1 received routine					
	medications.						
	medications.						
	An interview wi	th the Licensed Practical					
		s conducted on 1/25/13 at					
	` ′	e LPN stated "Nursing					
		uld be completed					
	quarterly."						
	9-3-6(a)						

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Event ID: 41PC11

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	JETIPLE CC	ONSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	15G699	A. BUII	DING	00	01/25/	
		130099	B. WIN			01/25/	2013
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			AYES ST LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0342	with other member team, appropriate health measures limited to training detecting signs and dysfunction, first a and basic skills reneeds of the client Based on observer record review for (#1), the facility's to ensure staff we regard to a client Findings include The facility's repland/or investigat 1/14/13 at 12:03 1/7/13 reportable "Consumer (client walk-in patient a after being seen to Consumer was the hospital. Consumer factors after the consumer of difficulties the consumer of difficulties to relieve place to relieve placeto relieve published."	must include implementing ers of the interdisciplinary ers of the include, but are not direct care staff in and symptoms of illness or aid for accidents or illness, equired to meet the health of the interdisciplinary ers of the includent such action, interview and ers of 2 sampled clients in sursing services failed ere adequately trained in the includent reports along were reviewed on PM. The facility's erincident report indicated int #1) was seen as a set [name of doctor] office by MD (medical doctor) men direct admit to the mer was a direct admit to the mer was a direct admit to all] for evaluation and ideal truinating. He had a	W0:	342	Staff training was not complete as the catheter was discontinu. The nurse manager has writte guidelines put in place for the of foley drainage equipment. To client is no longer using a foley catheter. Wound tracking and repositioning records are in plate to ensure future compliance, staff will be trained as needed investigations will be conducted neglect is suspected.	ed. n use The / ace.	02/24/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G699	B. WIN	G		01/25/2013
NAME OF D	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	KOVIDEK OK SUPPLIER			6101 H	AYES ST	
	NORTHWEST IND			MERRII	LLVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		AM. Client #1's 1/8/13				
	hospital Confide					
	Information Enclosed record indicated					
	client #1 was admitted to the hospital as					
	the client could not urinate on $1/7/13$. The					
	sheet indicated client #1 was discharged					
	back to the group home with a Foley					
	Catheter.					
	Caulicies.					
	Client #1's 1/8/13 Health and Safety					
	Memo (risk plan) from LPN #1 was					
		viewed on 1/15/13 at 3:45				
	1 ^	indicated the following:				
	"Instructions for	catheter care:				
	-Keep the bag be	elow the waist at all times				
	-Bag needs to be	hung on the frame of the				
	bed at bedtime. I	t CANNOT be placed on				
	the floor					
	-Make sure the r	ubber tubing is 'free of				
	kinks at all times	s'-Empty the bag into the				
	white basin befo					
		ount of urine using the				
		sin and record it on the I				
		te & output) sheet daily				
	, , ,	wash your hands before				
	I -	ng the catheter and wear				
		ndling the urine bag				
	_					
		ine output in 4 hours call				
	your nurse imme	ediately				
	In all Control	1				
	Instructions for l	eg bag:				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		15G699	B. WING	j		01/25/	2013
NAME OF F	PROVIDER OR SUPPLIEF	3			DDRESS, CITY, STATE, ZIP CODE		
					AYES ST		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		plastic tubing from the					
	catheter bag						
	-Connect the tubing to the leg bag						
	_	g on the inside of the leg					
	_	bove and below the knee					
	_	os for a comfortable fit					
		straps are not too tight and					
	cutting off circulation						
	-The leg bag is t	o be worn only during the					
	day						
	-Empty the leg bag every 2 hours as						
	needed and reco	rd the output on the I & O					
	sheet						
	-If there is no ur	ine output in 4 hours call					
	your nurse imme	ediatelyS/S (Signs and					
	Symptoms) for a	a client with a Foley:					
	1. Temperature	greater than 101					
	2. Persistent nau	usea and vomiting					
	3. Redness, tend	derness, or signs of					
	infection, pain, s	swelling, redness, odor or					
	green/yellow dis	scharge around site					
	4. Severe uncon						
		eathing, headache or					
	visual disturband						
	6. Hives						
	7. Persistent hea	adaches or visual					
	disturbance						
	8. Extreme fatig	gue					
	_	th or inability to urinate					
	I -	oncerns call nurse."					
	3. 1 === 3 3 2 2 2 2 1 2						
	The facility's ins	service/training records					
		on 1/15/13 at 1:12 PM.					
	1						1

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G699			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/25/2013
	PROVIDER OR SUPPLIE		6101 H	ADDRESS, CITY, STATE, ZIP CODE AYES ST LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Individual Train Reports indicate and #5 in regard Catheter and car inservice record trained day serv on 1/10/13. The records indicate and #10 on 1/11 inservice record trained staff #1 signed as the trained staff #1 signed as the trained staff #1 records indicate services failed to in regard to clie care. The facility trained in regard #1's risk plan/he informed the nure facility trained in regard #1's risk plan/he informed the nure facility trained in regard #1's risk plan/he informed the nure followed to the facility trained in regard #1's risk plan/he informed the nure followed to the facility trained in regard to the facility trained in reg	/13 observation period M and 8:10 AM, at the ff #2 worked as the night			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		15G699	B. WIN			01/25/2	013
NAME OF	PROVIDER OR SUPPLIEF	8			DDRESS, CITY, STATE, ZIP CODE		
400.05	NODEL WATER IND	IANIA INIC. THE			YES ST		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	1	vacation. When asked if		IAG	Birchitery		DATE
	there was a written protocol, staff #1 indicated she did not know. Staff #1 was						
	not able to locate						
	memo/protocol/risk plan in the home on						
	1/15/13.						
	Interview with Program Coordinator (PC)						
	#1 and LPN #1 on 1/15/13 at 1:50 PM						
	indicated client #1 had been hospitalized						
	for urinary retention. LPN #1 indicated						
	client #1 was discharged from the hospital						
		0/13. LPN #1 indicated					
		s doctor on 1/7/13 and					
		the hospital on 1/7/13.					
		d she assessed the client					
	on 1/12/13 (Satu	irday) when she had the					
	,	ER. LPN #1 stated she					
	stopped by the g	roup home to check on					
	client #1 when s	he noticed client #1's					
	penis was "swol	len, red with pus coming					
	out of penis." L	PN #1 stated "They					
	(facility staff) di	d not call me. They					
	should have call	ed." LPN #1 and PC #1					
	indicated facility	staff was trained in					
	regard to the car	e of the Foley Catheter					
	and when to call	the nurse. PC #1 and					
	LPN #1 indicate	d they were not aware					
		2 had not been trained in					
	regard to client #	‡1's Foley Catheter.					
	Interview with s	taff #1 on 1/15/13 at 3:46					
		e memo for client #1's					
		vas found/located in the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G699			LDING	00	COMPLETED 01/25/2013			
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 6101 HAYES ST MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	on 1/15/13 at 3:4	oook at the group home 6 PM.						
	1/16/13 at 12:10 staff #3 and #10 (Saturday) with chome. Administ staff #3, #5 and # (Friday) at the grantioned inservindicated staff #3 trained in regard Catheter protocol	dministrative staff #3 on PM, by phone, indicated worked on 1/12/13 elient #1 at the group rative staff #3 indicated #10 worked on 1/11/13 oup home. The above rice/training records 8, #5 and #10 had been to client #1's Foley l/risk plan, but failed to regard to client #1's nge.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G699		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/25/2013		
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 6101 HAYES ST MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
W0369	assure that all dru are self-administer without error. Based on observing record review for administered, the administer client error. Findings include During the 1/15/between 5:30 AM group home, clien asal medication medication pass Client #2's Medin Record (MAR) wat 8:10 AM. Client dicated client #5 Fluticasone spraying each nostril dath 1/13 MAR resinitialed as adminimitialed as adminimitialed as adminimitialed as adminimitialed as adminimitialed as order physician's order	rug administration must rugs, including those that bered, are administered ation, interview and r 1 of 28 doses refacility failed to #2's medication without 13 observation period of and 8:10 AM, at the rent #2 did not receive any retreatment at the morning rat 6:35 AM. 14 cation Administration revas reviewed on 1/15/13 rent #2's 1/13 MAR retreatment at the morning rate was to receive r	W0	369	Group home staff will be re-trained on medication administration. To ensure fut compliance, Service Coordina will monitor twice monthly for months and monthly thereafter.	ator 3	02/24/2013

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				onstruction 00	(X3) DATE COMPL			
		15G699	A. BUI B. WIN	LDING IG		01/25/		
NAME OF B	DOWNER OF CURRINE		D. WII		ADDRESS, CITY, STATE, ZIP CODE			
	ROVIDER OR SUPPLIER		6101 HAYES ST					
	NORTHWEST IND			MERRIL	LVILLE, IN 46410			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE	
		taff #1 on 1/15/13 at 8:25	1					
		ient #2 did not receive the						
	Fluticasone nasa	l spray at the morning						
	medication pass.	Staff #1 stated "I will						
	give it right now	."						
	9-3-6(a)							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G699		A. BUI	LDING	00	(X3) DATE COMPL 01/25 /	ETED	
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 6101 HAYES ST MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
W0436	repair, and teach informed choices eyeglasses, heard communications a devices identified team as needed by the Based on record facility failed to adaptive equipm (clients #1 and #1 for mobility. Findings include 1. A review of the incident/accident on 1/14/13 at 12 reports indicated Incident report do #1]'s brake on the wheelchair is brown the wheelchair is brown as well as wheelchair used a wheelchair is deviced and incident incident is deviced and incident in	furnish, maintain in good clients to use and to make about the use of dentures, ing and other aids, braces, and other by the interdisciplinary by the client. review and interview, the assure the repair of ent for 2 of 3 clients 4) who used a wheelchair : the facility's internal treports was conducted at 5 P.M Review of the eright side of his oken and will not lock." at #1's record was 15/13 at 11:31 A.M #1's record indicated he in at all times for cord failed to indicate chair had repairs wheelchair.	WO	436	Client #1 & 4 had their foot rand brakes repaired on 1/18 Client #4 cushion is in the process of being repaired. To ensure future compliance, wheelchairs will be repaired needed.	/13.	02/24/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
15G699			B. WIN	G		01/25/2013	
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					AYES ST		
ARC OF NORTHWEST INDIANA INC, THE			MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	`) was conducted on					
		P.M The SC indicated					
	she was not awa	re of client #1's					
	wheelchair need	ing repairs.					
		15/13 observation period					
		M and 8:10 AM, client #4					
	utilized a wheeld	chair for ambulation.					
	Interview with o	lient #4 on 1/15/13 at					
		ated his wheelchair					
	1	aired. Client #4 indicated					
		uld not stay up when he					
	_	et up from the wheelchair.					
		ed he needed his brakes					
		as they did need repair.					
	Client #4 also sta	ated he needed a "soft					
	cushion" for his	wheelchair. Client #4					
	indicated he had	told Program					
	Coordinator (PC) his wheelchair needed					
	work.						
		d was reviewed on					
	1/15/13 at 12:48	PM. Client #4's 12/9/12					
	Individual Suppo	ort Plan indicated client					
	#4 utilized a who	eelchair for mobility. The					
		d the client utilized a gait					
		get out of his wheelchair					
	_	Client #4's ISP and/or					
	•	dicate the clients					
	wheelchair was t						
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	Interview with P	C #1 on 1/16/13 at 12:20					
	PM, by phone, in	ndicated she was not					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL			
		15G699	A. BUI B. WIN	LDING G		01/25/	2013	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•		
ARC OF NORTHWEST INDIANA INC, THE			6101 HAYES ST MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	aware client #4's repaired until ye (1/15/13). PC # a cushion but chindicated client # in place to teach	wheelchair needed to be						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
		15G699	B. WIN			01/25/	2013
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				AYES ST		
ARC OF NORTHWEST INDIANA INC, THE					LLVILLE, IN 46410		
				WILKIKI			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG W0460		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Each client must well-balanced die	RITION SERVICES receive a nourishing, t including modified and					
	specially-prescrib	ed diets.					
	interview for 1 o (client #2), the fa	ation, record review and f 2 sampled clients acility failed to assure the od in accordance with the r.	Wo	460	Group home staff will be re-trained on client #2 diet (ground meats and chopped foods).To ensure future compliance, Service Coordinat will monitor twice monthly for 3 months and monthly thereafter	3	02/24/2013
	Findings include	:					
	the group home of P.M. until 6:15 F Direct Support P went into the refired apple and har	ervation was conducted at on 1/14/13 from 5:00 P.M At 5:30 P.M., professional (DSP) #1 rigerator and retrieved a nded it to client #2, who lient #2's apple was not of ee.					
	between 5:30 AM group home, clie group home eating gave the client for did not chop and apple. At 7:10 A second apple into gave the apple to table.	13 observation period M and 8:10 AM, at the ent #2 walked around the ing a whole apple staff #2 or breakfast. The staff /or cut up client #2's AM, staff #1 cut up a o bite size pieces, and o client #2 to eat at the					
	11 TO VICW OF CITCE	nt 112 5 100010 was					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G699		A. BUILDING B. WING	COMPLETED 01/25/2013					
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6101 HAYES ST MERRILLVILLE, IN 46410						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	BE COMPLETION					
	conducted on 1/15/13 at 11:30 A.M Review of the record included a nutritional assessment dated 1/27/12 which indicated he was on a chopped diet with ground meats.							
	An interview with the Service Coordinator (SC) was conducted on 1/15/13 at 2:10 P.M The SC indicated client #2's apples should have been chopped as his diet order indicated. The SC further indicated staff should ensure clients are eating their recommended diets.							
	9-3-8(a)							

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